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Child Parent Relationship Therapy: Hope for Disrupted Attachment

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To the Graduate Council:

I am submitting herewith a dissertation written by Carolyn Carlisle Hacker entitled "Child Parent Relationship Therapy: Hope for Disrupted Attachment." I have examined the final electronic copy of this dissertation for form and content and recommend that it be accepted in partial fulfillment of the requirements for the degree of Doctor of Philosophy, with a major in Educational Psychology.

Tricia McClam, Major Professor

We have read this dissertation and recommend its acceptance:

Ralph G. Brockett, Teresa A. Hutchens, Marianne Woodside

Accepted for the Council:
Carolyn R. Hodges

Vice Provost and Dean of the Graduate School

(Original signatures are on file with official student records.)

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Child Parent Relationship Therapy: Hope for Disrupted Attachment

A Dissertation

Presented for the

Doctor of Philosophy

Degree

The University of Tennessee, Knoxville

Carolyn Carlisle Hacker

December 2009

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This dissertation is dedicated with gratitude to ***God,*** Jehovah Rafa, the God of healing and the God of second chances. Thank you for many second chances and the opportunity to realize my dream of becoming a professor.

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- Students past, present and future: It is impossible for us to fully understand how the

work we do will impact the world. Nor can we know how a kind smile, a willing heart, or our ability to truly listen will ease the way for someone who is hurting. It is important to remember that the work we do will send forth ripples in the water, ripples we have no control over and that will extend beyond our influence. So send forth those ripples; with care, with forethought and always with unconditional positive regard and the imprint you leave will be far reaching. May God richly bless the work you do on behalf of His children. Godspeed.

Abstract

The purpose of this study was to determine if Child Parent Relationship Therapy (CPRT) was an effective method of treatment for reducing behaviors associated with attachment difficulties experienced by foster children who have been removed from their family of origin. This study also sought to determine if the age of the foster child, the gender of the foster child, or the number of foster placements would also influence behaviors associated with attachment difficulties. This study was conducted with a pre-test, post-test, quasi-experimental group, control group design format using the Randolph Attachment Disorder Questionnaire (RADQ) assessment instrument. The quasi-experimental group received the CPRT intervention and the control group participated in a support group. Results indicated no significant group interaction was found demonstrating that improvement in overall behaviors associated with attachment difficulty did not differ between the two groups. However, both the quasi-experimental group and the control group demonstrated a significant improvement in behaviors associated with attachment difficulty over time. When the two groups were compared using the subscales of the RADQ, the control group demonstrated a significant difference in the social subscale. There were no significant difference between the quasi-experimental and control groups' mean scores on the basis of age, however, the subscales of the post-test of the quasi-experimental group indicated an improvement in at least one subscale. There were no significant findings in relation to the total RADQ scores in regard to gender or in relation to the number of foster placements experienced by the child. The implications of these findings are discussed and directions for future research are also presented.

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CHAPTER ONE

Introduction

"As the twig is bent, so grows the tree" is an expression that provides visualization for the concept that early childhood experiences and patterns of behavior tend to shape and impact a child throughout his or her lifetime (Kraft & Landreth, 1998). Findings indicate that this is especially true of the parent and child attachment, which becomes the framework for all future relationships and core beliefs (Gray, 2002). First attachments form the foundation upon which a child's personality, intimate relationships, emotional awareness, social interactions and self-acceptance are formed (Green & Scholes, 2004). When a child is securely attached, the child learns that he or she is loved and that the world is a safe place where caring adults will meet his or her needs (Levy & Orlans, 1998). The child then learns trust and reciprocity that serve as the basis for all future relationships (Brisch, 2002, Levy & Orlans, 1998). He or she is free to explore the environment with feelings of safety and security, thus facilitating healthy cognitive and social development (Gray, 2002). Secure attachment allows the child to establish an identity that includes a sense of competency and self-worth and allows him or her to balance dependence needs and the need for autonomy (Levy & Orlans, 1998). According to Levy and Orlans (1998), the development of empathy, compassion, and a conscience are also by-products of secure attachment. When a child is securely attached, he or she has a defense against stress and trauma and can develop resourcefulness and resilience (Gray, 2002).

Children with healthy attachments have a framework for regulating frustration and anxiety, reducing pain, and developing appropriate emotional responses and feelings

(Levy & Orlans, 1998). This in turn, paves the way for the development of self-control and mastery skills that will be needed throughout the child's lifetime. The child that is not able to form a secure attachment is at risk for serious developmental problems and may be incapable of genuine trust, the foundation for intimacy and affection (Green & Scholes, 2004). Insecure attachments can lead to low self-esteem, antisocial attitudes and behaviors, aggression and violence, and behavioral and academic problems (Gray, 2002). The child may be unable to develop or maintain friendships and can alienate himself/herself from parents and other authority figures (Penzerro & Lein, 1995). He or she may become anxious, frustrated, angry, stressed, helpless, hopeless and at times, hyper-vigilant and even dissociative (Levy & Orlans, 1998). The child may fail to develop a conscience; consequently, he or she will have little or no empathy for others (Fahlberg, 1979). Without intervention, the child may be unable to develop appropriate emotional responses and feelings of self-control and mastery skills needed to function in society (Gray, 2002). Children with attachment disorders may become adults diagnosed with antisocial, narcissistic, and/or borderline personality disorder (Green & Scholes, 2004).

According to Lamb, Gaensbauer, Malkin and Shultz (1985), children with insecure attachments are likely to exhibit deficient social skills and problem solving abilities. Other difficulties for children with insecure attachments include poor awareness of cause and effect relationships, delayed motor skill development, inconsistent physical and cognitive development and impaired conscience are consequences of failed attachment (Fahlberg, 1979). Penzerro and Lein (1995) indicated that children with attachment issues are more likely to experience learning difficulties at school, are less

selective regarding relationships, and are more hostile and isolated from peers. In addition, coping skills are also influenced by attachment, and children with avoidant attachments may develop patterns of defensiveness and denial in their relationships with others (Delaney, 1991). Furthermore, anxiously attached children, "are less ego-resilient, less independent, less compliant, less empathic, less socially competent, and lower in self-esteem than securely attached children" ((Penzerro & Lein, 1995, p. 353).

Foster children are at risk for insecure attachments and attachment disorders as a result of inappropriate care giving experiences such as abuse, neglect, deprivation, parental substance abuse, and attachment disruption which involve behavioral consequences (Delaney, 1991). Because maltreated children often experience abandonment and disturbed parent-child relationships, they are likely to develop abnormal emotional, linguistic, and cognitive development (Eagle, 1994; Silver, Amster, & Haecker, 1999). In addition, maltreated children are at risk for emotional withdrawal, denial of negative feelings, and flattened affect and as a result, lack the cognitive and emotional abilities or resources to cope with stressors (Eagle, 1994).

Behavioral manifestations of maladaptive attachment exhibited by children who have been maltreated may include anti-social behavior such as fire starting, sexual molestation, animal abuse, cruelty to siblings and others, as well as the inability to accept or reciprocate affection (Levy & Orlans, 1998). Other behavioral expressions associated with maltreatment and attachment difficulties include superficial and charming behavior, indiscriminate affectionate behavior with strangers, destructive behavior to self and others, poor peer relationships, lack of age appropriate-guilt, poor impulse control and the inability to learn from consequences, repressed rage, and high pain tolerance (Fairchild,

2006; Randolph, 2000). Removal from the family of origin and placement in foster care has the potential to further negatively impact the child's ability to attach as once in foster care, children may continue to experience separation and disrupted attachment due to unstable placement, breaks in placement, or when being placed back into the family of origin only to be removed again (Silver, Amster, & Haecker, 1999).

There are currently over 500,000 children in the United States who are residing in out-of-home placement (Blatt, 2000) and an additional 500,000 children are living with family, friends, in shelters or are on runaway status and are not legally considered placed (United States Department of Health and Human Services, Children's Bureau, 2008). This statistic indicates that one million American children are at risk for disrupted attachment and its accompanying difficulties and social issues. According to the Adoption and Foster Care Analysis and Reporting System Report of 2008, the average length of stay in foster care is one and a half years, although many children stay in foster care for a much longer time. Approximately two thirds of foster children will be reunited with their family of origin (with 15% of children entering foster care having previously been in placement) and ten percent of the children in foster care will be adopted, many times by their foster parents (United States Department of Health and Human Services, Children's Bureau, 2008).

Whether or not the child returns to the family of origin, the foster care experience has the potential to offer the child the opportunity to see how other families live and the opportunity to develop new skills or behaviors that can be of benefit to him or her (George, Wulczyn, & Fanshel, 1994). Therapeutic intervention while in foster care may be the catalyst for such a positive outcome (Minde, 2003).

Early intervention and treatment of insecure attachments can avert the development of serious health issues and psychological problems (James, 1994). Theories that explore the etiology of attachment difficulties focus on the following: 1) absence of a primary attachment relationship (Bowlby, 1969), 2) maltreatment (Levy & Orlans, 1998), 3) characteristics of the child or the parent (Brisch, 2002), 4) social events (Gray, 2002), 5) genetic factors (Ijzendoorn, 1997), and 6) life events (Gray, 2002). As a result, treatment of children and families affected by attachment difficulties typically attempt to enhance current attachment relationships, create new attachment relationships, and reduce problematic symptoms and behaviors through psychoeducational training and or psychotherapy (Cornell & Hamrin, 2008; Hardy, 2007). Helping foster children develop secure attachments is imperative to the child's well-being and to the well-being of society as a whole (Silver, Amster, & Haecker, 1999). When foster parents are included in the treatment process, efficacy increases (Pearce & Pezzot-Pearce, 2002). Consequently, it is logical to introduce a treatment modality that includes foster parents.

The focus of a psychoeducational approach to treatment is to increase the parent's knowledge of child development, to facilitate relationship development between the parent and child, and to teach the parent coping and self-care skills (Cornell & Hamrin, 2008). The goal of this type of intervention is to improve the relationship between the parent and child as a direct result of parental support and education.

Psychotherapy for attachment issues may involve the parent, the child, or may include both the parent and the child. Psychotherapy treatment for the parent focuses on training parents in basic child development, parenting skills such as soothing behavior, responding to the child's social cues, alerting a withdrawn child, and reciprocating the

child's overtures of engagement (Carmen, 1994). In addition, child management strategies or education of the child's behavioral difficulties are included in the treatment process so that parents or caregivers do not personalize the child's negative behaviors (Pearce and Pezzot-Pearce, 2002).

Psychotherapeutic intervention for the child typically focuses on changing problematic behaviors that are associated with attachment difficulties (Carmen, 1994). In some cases, play therapy has been used for attachment intervention. Overall, psychotherapy as a treatment modality focuses on improving the attachment relationship between the parent and child by changing maladaptive internal representations (Cornell & Hamrin, 2008).

Filial Therapy is a treatment option for children and care givers that may provide hope for changing maladaptive internal representations (Landreth, 2002). The goal of Filial Therapy is to facilitate a positive relationship between a parent figure and the child and to eliminate behavioral problems (Watts & Broaddus, 2002). This treatment modality utilizes a psychoeducational intervention model whereby therapists trained in client-centered play therapy teach parents basic therapeutic skills including responsive listening, therapeutic limit setting, building self-esteem, conducting weekly play sessions with their child, selecting an environment for play, and selecting toys and materials to be used in the process (Landreth & Bratton, 2006). The therapist then demonstrates play sessions, and empowers the parent to conduct similar sessions in his or her own home (Landreth, 2002). Finally, the therapist provides ongoing supervision and feedback to the parents (Watts & Broaddus, 2002). Filial Therapy allows caregivers to become agents of change with their children by creating a non-judgmental, accepting and understanding

environment in which the parent-child relationship can develop (Landreth, 2002). Personal growth for both the caregiver and the child can result (Landreth & Bratton, 2006).

Filial Therapy focuses on the caregiver-child relationship by utilizing the child's natural language of play as the means for communication between the caregiver and child (Landreth, 2002). Children are encouraged to take the lead to develop self-responsibility as well as self-control. As a result, the caregiver's perception of the child and the child's perception of the caregiver change (Landreth & Bratton, 2006). This is in direct contrast to other parenting programs which focus on problem solving techniques or on changing the child's behavior through verbal interactions or lecture format (Landreth, 2002). Conversely, Filial Therapy is a treatment modality that is not dependent on verbal interactions and does not utilize a lecture format; furthermore, caregivers are not viewed as being in charge of resolving the child's problems. The ultimate goal of Filial Therapy is to strengthen the relationship between the parent and the child by increasing feelings of warmth, affection, empathy, and trust and to diminish the child's presenting behavioral problems (Landreth & Bratton, 2006). The goal of this investigation is to determine if Filial Therapy, in particular the Child-Parent-Relationship Therapy (CPRT) model of Filial Therapy, will affect the observed behaviors exhibited by foster children with attachment problems and if CPRT is an effective treatment for foster children with attachment difficulties.

Statement of the Problem

Children are vulnerable to experiences that place them at risk for attachment difficulties. Some of the factors that influence a child's ability to attach or lose

attachment once it has been formed include 1) separation from parents; 2) adoption after attachment to another parent figure has occurred; 3) prenatal exposure to drugs and or alcohol; 4) traumas such as physical, sexual, emotional abuse or domestic violence; 5) major depression, schizophrenia, or bipolar illness in the parental figure; 6) substance abuse in the parent figure; 7) institutionalization; 8) hospitalization of either the parent or the child during which time the child looses access to the parent figure (Gray, 2002).

Foster children may experience attachment disruption as a result of their removal from their family of origin and their placement in an alternative parenting arrangement. Attachment disruption often leads to difficulties in forming trusting relationships and, as a result, foster children have inadequate relationship skills. This presents a substantial challenge to those who attempt to help them, such as foster families, mental health professionals, child welfare systems, juvenile justice systems, and school systems (Solomon & George, 1999).

Therapeutic interventions designed to assist children with attachment difficulties and to help them form trusting relationships could be extremely beneficial to the child (Pearce & Pezzot-Pearce 2000). The research literature, however, reported much ambiguity regarding the efficacy of treatment interventions for children with attachment problems (Brisch, 2002; Gray, 2002; Levy & Orlans, 1998; Lieberman, 2003). While attachment security appears to have profound implications for psychosocial functioning, traditional methods of therapeutic intervention are frequently ineffective with foster children as they tend to focus exclusively on the reduction of behavioral problems rather than healing attachment injury (McWey, 2004). In addition, when attachment is compromised, the child may have difficulty trusting or forming a working alliance, which

is essential to the success of the therapeutic intervention (Levy, 2000). The child's need to control, fear of closeness, and the inability to exhibit reciprocity may further complicate the therapeutic relationship (Gray, 2002). Attachment Therapy, a therapy that exists outside of the usual boundaries of psychology and medicine, attempts to heal attachment injury by using physical restraint and stimulation (Mercer, Sarner, & Rosa, 2003). Although attachment therapy has an extensive following, it is responsible for at least four deaths (p. 5-6).

This investigation will be concerned with determining the efficacy of CPRT as a method of intervention for foster children with attachment difficulties. CPRT is an intervention that includes the foster parent in the treatment intervention to maximize effectiveness and utilizes an assessment instrument that is simple, straightforward and easy to use by foster parents who will be completing the assessment. In addition, CPRT attempts to focus on relationship development rather than merely reducing the child's behavioral problems. Will CPRT be effective in effective in reducing behaviors in foster children that are associated with attachment difficulties? This study seeks to answer to this question.

Purpose of the Study

The purpose of this study is to determine if CPRT is an effective method of treatment for reducing behaviors associated with attachment difficulties experienced by foster children who have been removed from their family of origin. This study also seeks to determine if the age of the foster child, the gender of the foster child, or the number of foster placements will influence the behaviors associated with attachment difficulties. No previous empirical studies were found that sought to determine the effectiveness of CPRT

as an intervention for children with attachment injuries. This study attempts to address this gap in the empirical literature.

A limited number of Filial Therapy studies have sought to determine the efficacy of CPRT as a Five-Session training program as CPRT is typically a 10-Session intervention. In an attempt to facilitate participation, CPRT has been adapted from a 10-Session to a Five-Session training program with documented success (Harris & Landreth, 1997). This study attempts to add to the empirical body of literature regarding the effectiveness of the Five-Session CPRT program design.

No empirical literature was found that utilizes foster parents as agents of change with foster children in regarding to behaviors associated with attachment difficulty; nor were research studies found that examined the efficacy of CPRT in diminishing behaviors associated with attachment issues. Potential benefits to both the foster child and the foster parent may result when foster parents, through CPRT, are allowed the opportunity to be such a change agent. These benefits include: 1) less dependence on a professional for therapeutic assistance; 2) the foster parent has the potential to be more effective in interacting with the foster child; and 3) there is greater potential for lasting changes as foster parents will continue to use the skills acquired in CPRT throughout their relationship with the foster child (Landreth & Bratton, 2006). This study aims to address the gap in the empirical literature regarding the effectiveness of foster parents as therapeutic change agents in the lives of foster children.

This research study attempts to address the gap in the literature regarding the effectiveness of Filial Therapy as an intervention to diminish behaviors associated with

attachment difficulties in foster children with attachment problems, and to improve relationships between foster parents and foster children.

Research Questions

CPRT is a therapeutic intervention with demonstrated effectiveness in facilitating positive relationships between parents and children. Will CPRT be effective in facilitating attachment behaviors in foster children with attachment difficulties? This study seeks to provide answers to the following research questions:

Research Question 1: Will the quasi-experimental group score significantly lower ($p < .05$) on the total RADQ score of behaviors associated with attachment difficulty when compared to the total RADQ score of the control group subsequent to the CPRT intervention?

Hypothesis 1: There will be no significant difference in the quasi-experimental group's change in total RADQ score of behaviors associated with attachment difficulty when compared to the change in the total RADQ scores of the control group.

Research Question 2: Will the quasi-experimental group score significantly lower ($p < .05$) on the subscales of the RADQ score of behaviors associated with attachment difficulty when compared to the subscales of the RADQ scores of the control group subsequent to the CPRT intervention?

Hypothesis 2: There will be no significant difference on the quasi-experimental group's subscale scores of behaviors associated with attachment difficulty when compared to the subscale scores of the control group.

Research Question 3: Will the age of the foster child influence the behaviors associated with attachment difficulties?

Hypothesis 3: The mean score of behaviors on the RADQ associated with attachment difficulties exhibited by older children will not differ from the mean score of behaviors on the RADQ exhibited by younger children.

Research Question 4: Will the gender of the foster child influence the behaviors associated with attachment difficulties?

Hypothesis 4: The mean score of behaviors on the RADQ associated with attachment difficulties exhibited by male foster children will not differ from the mean post-test score of behaviors on the RADQ exhibited by female foster children.

Research Question 5: Will the number of foster home placements experienced by the foster child influence behaviors on the RADQ associated with attachment difficulties?

Hypothesis 5: The mean RADQ scores of foster children who have experienced multiple foster placements (more than one) will be equal to the mean RADQ scores of children who have experienced one placement.

Delimitations

The boundaries of this study are established through the pre-test, post-test, quasi-experimental, and control group design of the investigation. Helping foster parents in the quasi-experimental group develop skills that will help to reduce behaviors that are associated with attachment difficulties in foster children is the focus of the study. Foster children, however, will be indirect participants in this investigation as they will be participating in bi-weekly play sessions with their foster parent. In order to maintain the confidentiality of foster children, there will be no videotapes of CPRT sessions between foster parents and foster children. As a result, the investigator will have the expectation

that the foster parents will conduct CPRT sessions and that they will conduct sessions according to principles learned during training. Furthermore, the investigator will have the expectation that the foster parents will describe the play sessions they conduct with their foster children accurately when they discuss the sessions with the investigator and the CPRT group. Subsequent to this research study, any foster parents assigned to the control group will have the opportunity to participate in CPRT training. Although this study will attempt to prove the effectiveness of CPRT, this intervention does present potential limitations.

Limitations

This study is limited by seven factors that may affect the outcome of this research. First, foster care living arrangements have the potential to result in a break in placement; consequently, it may be difficult for foster children to change attachment behaviors for someone who they may perceive as being transient in their life. Second, if the foster child's placement in the home is disrupted during the course of the study, the foster child will no longer participate. Although every effort will be made to ensure the foster placement of participants is secure prior to participation, this can not be guaranteed. Third, foster parents who tend to utilize an authoritarian parenting style must be able to relinquish this mode of parenting in favor of an authoritative approach to parenting that will be introduced in the CPRT training. The foster parent who is unable to do so may not benefit from CPRT training, and as a result, neither may the foster child. A fourth limitation is that foster parents will be introduced to a variety of new skills that they must be willing to practice between sessions according to training principles, even if they are skeptical regarding outcome. Fifth, foster parents must participate in all sessions and

must conduct special play time with their foster child on a weekly basis in the home two times a week for 30 minutes per play time. If the foster parent does not initiate play sessions on a regular basis, there is a potential for outcome variables to be affected adversely. Sixth, the research instrumentation is a self-report instrument whereby foster parents will measure attachment behaviors exhibited by the foster child. Although this instrumentation is precise in nature, it may not capture the subtle shifts in attitudes and perceptions of the foster parent. Finally, the researcher will be implementing this intervention with foster parents and has seen first hand the efficacy of Filial Therapy in facilitating positive relationships between children and significant others that result in behavior change on the part of both parent and child. As a result, the investigator must safe guard against subjective bias by adhering strictly to the research design. Despite the limitations noted this study will add to the empirical literature regarding CPRT and its significance for foster children and foster families.

Significance of the Study

This research will add to the literature regarding the effectiveness of CPRT in three ways. First, this study seeks to determine the efficacy of CPRT in affecting the observed behaviors that foster children with attachment problems exhibit. No empirical research studies were found that have examined the effectiveness of CPRT for diminishing behaviors that are associated with attachment issues. Second, this study seeks to add to the limited research literature regarding the effectiveness of the 5-Session format of CPRT. Finally, this study aims to address the gap in the empirical literature regarding the effectiveness of foster parents as therapeutic change agents in the lives of foster children.

Additional significance may be derived from CPRT if an improved relationship between the foster parent and the foster child occurs. Secondary benefits may result if improved relationships are generalized to the biological parent, thus improving the relationship between the parent and the child. In addition, presenting behavioral problems exhibited by the child may also be decreased or extinguished subsequent to the CPRT intervention. Benefits may also result if improvements are generalized to other settings such as social relationships, school settings, etc. A further benefit may be derived to foster children, the Department of Children's Services and society as a whole if improved relationships between the foster parent and the foster child prevent disruptions in the foster child's placement.

Attempting to add to the empirical literature regarding the effectiveness of this intervention will involve the use of key terms. The precise meaning of these terms will help to clarify important concepts involved in this investigation and will help to describe key elements of the research.

Definition of Terms

Aggressive behavior refers to behavioral problems that involve acting out towards others that are characterized by physical violence, cruelty, outbursts of temper, verbal altercations or destruction of property (Randolph, 2000).

Ambivalent attachment is defined as an attachment formation that is expressed primarily through anger, defiance, rage, manipulation, and the rejection of affection based on the need for control (Ainsworth, M., Blehar, M., Waters, E., & Wall, S., 1978).

Asocial behaviors is defined as difficulty making eye contact, engaging in dangerous activities, high pain tolerance and refusing comfort when hurt, teasing,

hurting, or cruelty to animals, preoccupation with fire or fire setting; and fascination with violence (Randolph, 2000).

Antisocial behavior refers to the inability to express age appropriate guilt, destruction of property, impulsivity, lack of cause and effect thinking, and tendency towards being accident prone (somatic) (Randolph, 2000).

Anxious attachment refers to an attachment formation that is expressed by clinging behavior or fear of separation from the attachment figure (Ainsworth, M., Blehar, M., Waters, E., & Wall, S., 1978).

Avoidant attachment is defined as an attachment formation that is expressed by isolated behavior, avoidance of relationships, and rejection of affection based on fear of others or the failure to enjoy the company of others (Ainsworth, M., Blehar, M., Waters, E., & Wall, S., 1978).

Attachment disruption refers to an interruption in attachment between the child and his or her natural or adoptive parents stemming from the foster child's removal from his or her family of origin or adoptive placement (Gray, 2002).

Behaviors associated with attachment difficulties resulting from avoidant, anxious, ambivalent, or disorganized attachment formation and refer to the following: 1) superficially and engaging, charming behavior; 2) indiscriminately affectionate behavior with strangers; 3) destructive to self, others, and possessions; 4) developmental lags; 5) lack of eye contact; 6) lack of demonstrative behavior with caregivers; 7) cruelty to animals, siblings or others; 8) lack of cause and effect thinking; 9) poor peer relationships; 10) inappropriately demanding or clinging; 11) engaging in stealing or lying behavior; 12) lack of age appropriate-guilt; 13) engaging in persistent nonsense

questions, incessant chatter, or arguing; 14) abnormal speech patterns; 15) poor impulse control; 16) controlling behavior; 17) does not learn from consequences; 18) makes false accusations; 19) will not allow caregivers to comfort him or her; 20) sneaks things, even though he or she could have them if he or she had asked; 21) can't keep friends for more than a week; 22) throws tantrums; 23) accident prone; 24) doesn't do well in school, but could do well if he or she put forth effort; 25) sets fires or is preoccupied with fire; 26) prefers violent shows or movies; 27) engages in hording or gorging on food; 28) engages in risk taking behavior; 29) repressed rage; 30) high pain tolerance; and 31) was abuse or neglected, experienced severe chronic pain, had more than one caregiver, was separated from his or her mother for more than two days, or was in an orphanage during the first two years of his or her life (Randolph, 2000).

Child-Parent-Relationship Therapy (CPRT) is:

> A unique approached used by professionals trained in Play Therapy to train parents to be therapeutic agents with their own children through a format of didactic instruction, demonstration play sessions, required at-home laboratory play sessions, and supervision in a supportive atmosphere. Parents are taught basic child-centered play therapy principles and skills including reflective listening, recognizing and responding to children's feelings, therapeutic limit setting, building children's self-esteem and structuring required weekly play sessions with their children using a special kit of selected toys. Parents learn how to create a non-judgmental, understanding, and accepting environment that enhance the parent-child relationship, thus facilitating personal growth and change for child and parent. (Landreth & Bratton, 2006, p. 11)

For the purpose of this study, CPRT is the model of Filial Therapy that will be utilized with foster parents and foster children. This model will be conducted using a five week approach.

Controlling behavior is defined as tremendous need for control, excessive arguing, demanding behavior, bossiness, tantruming, and academic underachievement (Randolph, 2000).

Delinquent behavior is defined as denying responsibility for actions, stealing, pathological lying, sneaking instead of asking for needs or wants, hoarding food, and speech oddities (Randolph, 2000).

Disorganized attachment refers to an attachment formation that is expressed by disorganized or bizarre behavior and emotional and frequent changes in mood. Children with a disorganized attachment style may be psychotic, developmentally delayed, or may have intellectual, speech, or neurological impairments (Levy, 2000; Randolph, 2000).

Empathy is defined as the ability to be sensitive to the needs and feelings of others and the ability to communicate this sensitivity to another person (Randolph, 2000).

Filial Therapy refers to a psycho educational intervention model whereby a therapist trained in client-centered play therapy teaches foster parents to be agents of therapeutic change with their foster children. Foster parents are educated in basic therapeutic skills including responsive listening, therapeutic limit setting, building self-esteem, conducting weekly play sessions, selecting an environment for play, and selection of toys and materials to be used in play sessions. Skills are taught to parents by the therapist who also demonstrates and role-models techniques and behaviors and serves as a supervisor to the therapeutic process. Foster parents learn to create an understanding

and accepting environment which facilitates personal growth of the child and enhances the foster parent-foster child relationship (Landreth & Bratton, 2006).

Foster child is defined by this study as a child who has been removed from his or her family of origin or adopted family and placed in a household where he or she is parented by someone other than the natural or adopted parents (Gray, 2002).

Foster parent is defined as an individual other than the child's natural or adoptive parent who acts as parent and guardian of the child but who has not legally adopted the child (Gray, 2002).

Fringe therapy is defined as an intervention that is presented outside of the boundaries of psychology and medicine and is unsubstantiated by empirical evidence (Mercer, Sarner, & Rosa, 2003). Fringe therapies have emerged in the form of anecdotal experiences of the therapist (Boris, 2005) and are not covered by insurance, not used in public hospitals or clinics, are not taught by accredited university programs, and are rejected by most credentialed mental health professionals and medical practitioners (Mercer, Sarner, & Rosa, 2003).

Indiscriminate affection refers to an inability to socially discriminate who one should be affectionate with and excessive familiarity with others including strangers (Levy & Orlans, 1998).

Play therapy refers to:

> A dynamic interpersonal relationship between a child and a therapist trained in Play Therapy procedures that provides selected play materials and facilitates the development of a safe relationship for the child to fully express and explore self

(feelings, thoughts, experiences, and behaviors) through the child's natural medium of communication; play. (Landreth, 1991, p. 14)

Social behavior refers to acting cute or charming in an attempt to manipulate others, being overly friendly with strangers, teasing, hurting or being cruel to other children, attempting to get sympathy from others by lying or embellishing, and the inability to keep friends (Randolph, 2000).

Social problems are defined as problematic behaviors exhibited by the child that include inability to get along with others, being disliked by others, and or teased, rejected, or mistreated by peers (Lamb, Gaensbauer, Malkin, & Shultz, 1985).

The above mentioned terms are important concepts and key elements involved in this investigation. The following organization information will detail the investigation process in its entirety.

Organization of the Study

This research study will consist of five chapters. Chapter One introduces the study and describes the significance and relevance of CPRT as an effective method of treatment for reducing behaviors associated with attachment difficulties experienced by foster children who have been removed from their family of origin. Chapter Two includes reviews of the literature in the following areas: 1) Filial Therapy; 2) Attachment Theory; 3) Attachment Theory and abuse and neglect; 4) attachment and anti-social behavior; 5) children in foster care; 6) foster children and attachment; and 7) attachment interventions. The research design and methodology is discussed in Chapter Three and includes methods, research questions, instrumentation, participants, procedures (including an overview of sessions), data analysis, and data trustworthiness and research bias. Chapter

Four will present the findings of this study and Chapter Five will discuss these findings and suggest areas for further research.

Summary

This chapter has presented an overview of the study, CPRT: Hope for Disrupted Attachment. The prevalence of foster children who experience attachment difficulties and a lack of effective treatment for facilitating secure attachment indicate that outcomes studies that address these issues are justifiable. The research design directs the focus of this study to the efficacy of a five week CPRT intervention in affecting the observed behaviors that foster children with attachment problems exhibit and whether or not CPRT is an effective treatment intervention for foster children with attachment difficulties. The research design further seeks to determine if there is an association between behaviors associated with attachment difficulties and the age of the foster child, the gender of the foster child, and the number of placements experienced by the child. Essential terminology involved in this study has been defined so that the meaning of each term is clarified in reference to its use in this research. The second chapter will review the literature on the topics of Filial Therapy, Attachment Theory, Attachment Theory and abuse and neglect, Attachment Theory and anti-social behavior, children in foster care, foster children and attachment, and attachment interventions.

CHAPTER TWO

Review of Literature

The following review of the literature is a synthesis of theoretical constructs and research related to the areas of Filial Therapy and Attachment Theory. Included in this review is the Guerney model of Filial Therapy, the Landreth Model, the use of Filial Therapy as a treatment modality, and its significance as an intervention for attachment issues. It further explores attachment in depth, especially as it pertains to children who have been abused, neglected, and or abandoned, and removed from their family of origin. Attachment Theory and it relationship to abuse and neglect, anti-social behavior, and children in foster care, is also reviewed. Finally, an overview of attachment interventions and Filial Therapy as a potential attachment intervention conclude the chapter.

Filial Therapy

Filial Therapy is a treatment option that may offer hope for children with attachment issues and disorders. It is a therapeutic intervention that is based on the theoretical construct of Child-Centered Play Therapy (CCPT) (Guerney, 1964; Landreth & Bratton, 2006). CCPT is based on Carl Roger's theoretical constructs of nondirective therapy that were founded in the belief that all humans have the potential to be self-directing and to move towards growth and maturity (Rogers, 1951). CCPT does not attempt to control or change the child; rather, it views the child's behavior as self-directed and motivated by growth, independence and self-realization (Landreth & Bratton, 2006). The agent of change within CCPT is the relationship between the therapist and the child, grounded in the therapist's acceptance of the child and belief that the child can be a change agent in his/her own life by leading the play experience

(Axline, 1947; Landreth, 1991/2002; Landreth & Bratton, 2006). Axline (1947) describes this process: "Through the process of self-expression and exploration within a significant relationship, through realization of the value within, the child comes to be a positive, self-determining and self-actualizing individual" (p. 5).

Play Therapy has been researched for over five decades. Bratton et al. (2005) conducted a meta-analysis of the Play Therapy literature and compared 93 treatment and control group studies. Results of this meta-analysis indicated that children who received Play Therapy interventions performed better (more than three fourths of a standard deviation) on outcome measures than children who did not receive such treatment. In addition, Filial Therapy was found to generate stronger evidence of effectiveness than play therapy and in fewer sessions (Bratton, Ray, Rhine, & Jones, 2005).

Filial Therapy teaches parents to apply child-centered play skills to their interactions with children in much the same way a therapist would apply principles and skills in Play Therapy (Landreth & Bratton, 2006). Because play is the primary language of children and the way in which children work through issues, the goal of Filial Therapy is to teach parents to be therapeutic change agents with their own children through the medium of play (Landreth, 2002).

Originally, Filial Therapy was designed as a long term therapeutic intervention (Guerney, 1994). Today, Filial Therapy has evolved into a short-term intervention that uses a psychoeducational intervention model based on client-centered, dynamic, behavioral and family systems (Landreth, 2002). Therapists teach, supervise and empower parents to conduct child-centered play sessions with their children (Landreth & Bratton, 2006). Typically, this method is utilized to facilitate positive relationships

between a parent and their child and to eliminate behavioral problems (Van Fleet, 1994). This is accomplished through psychoeducational instruction, play demonstrations conducted by the play therapist, required play sessions conducted in the home between the parent and the child, and ongoing supervision between the play therapist and the parents (Landreth & Bratton, 2006).

In a psychoeducational parent training format, the play therapist teaches parents basic therapeutic skills such as responsive listening, therapeutic limit-setting, building self-esteem, and how to have weekly play sessions with their child utilizing specially selected toys (Landreth, 2002; Landreth & Bratton, 2006). Therapeutic play sessions between the parent and child allow parents to become change agents when they create a non-judgmental, accepting, and understanding environment in which the parent-child relationship can develop (Landreth & Bratton, 2006). The result is personal growth for both the parent and the child. According to Louise Guerney (1997), " Filial Therapy adds what strictly behaviorally oriented psychoeducational training programs do not have - the nesting of the training in new behaviors within a humanistic approach to change . . . and both components are necessary to make therapy complete" (p. 157). Because the parent has an influential relationship with the child, teaching parents the skills of child-centered play therapy is likely to have a greater impact than if the child received play therapy from a therapist (VanFleet, 1994). According to VanFleet, such results would also be "more profound and longer lasting" (p. 3).

Parenting programs designed to help parents to be more proficient in their role typically focus on educating the parent to change the child or control the child's behavior (Landreth & Bratton, 2006). This, however, is not the focus of Filial Therapy which

instead focuses on changing the parent by increasing their parental effectiveness (Landreth, 2002).

Filial Therapy In Comparison to Other Parent Training Programs

Preparation for parenting is typically limited to the knowledge one receives from one's own childhood experiences (Bratton, 1994). As a result, many enter parenthood unprepared and unequipped to carry out their parental roles and obligations. Filial Therapy offers a different type of parenting program as it places the focus of the training on the child (Landreth & Bratton, 2006) and the child's most natural means of communication: play (Bettelheim, 1987).

Rather than focus on problem solving techniques, Filial Therapy focuses on the parent-child relationship (Guerney, 1964). In addition, Filial Therapy focuses on communication between the parent and the child utilizing play, as opposed to verbal interventions (Landreth, 1991). Other relationship models focus on the parent being in charge of resolving problems while Filial Therapy encourages the child to take the lead and to develop self-responsibility and self-control (Landreth & Bratton, 2006). Filial Therapy is experientially based and allows parents to try out and practice their new skills, rather than receive training in a lecture format (Landreth & Bratton, 2006). Finally, the goal of Filial Therapy is not to change the child's behavior but to change the child's perception of the parent, and the parent's perception of the child (Landreth, 2002; Landreth & Bratton, 2006). As a result, this treatment method offers parents new skills for relating to their children, and an opportunity to enhance their existing parenting abilities (Lobaugh & Landreth, 1998) and serves as a prevention strategy as well as an intervention (Garza, Watts & Kinsworthy, 2007). Historically, the delivery of the Filial

Therapy intervention has been based on the Guerney model or the Landreth model, both of which are considered family therapy approaches.

The Guerney Model

Filial Therapy was first introduced by Bernard Guerney in 1964 in response to the need for mental health services for children and families, which was often unavailable (Guerney, 1964). Initially developed for children ten years of age or younger who were experiencing significant behavioral or emotional difficulty, Filial Therapy was intended to be a long-term treatment intervention (Garza, Watts, & Kinsworthy, 2007). Guerney postulated that parents could serve as agents of change in the lives of their children in regard to emotional and behavioral problems and parents could take a more active role in their children's treatment. Because parents were viewed as the most influential persons in the child's life, Guerney believed that therapeutic change within the parent-child relationship would have the most impact. Thus, the term *Filial Therapy* was instituted to reference this natural bond between the parent and child (Landreth & Bratton, 2006). Parents who were typically excluded from the treatment process were now included, avoiding any perception of exclusion or failure on their part (Guerney, 1964). Guerney further established that including parents in treatment helped them function more adequately in their parental roles and helped avoid premature removal from therapy.

In the Guerney model of Filial Therapy, therapists trained parents in the skills of child-centered play therapy (Guerney, 1964). These skills included helping the parent to develop empathy and acceptance for the child and to interact with the child in a genuine and accepting manner through 30 minute play sessions. Through this interaction, the

relationship between parent and child was enhanced and the parent's perception of the child changed in a positive direction, as did the child's perception of the parent.

Although Guerney's Filial Therapy was a radical approach to child psychotherapy at the time (Landreth & Bratton, 2006), Guerney was influenced by predecessors such as Freud, Moustakas, Fuchs, and Baruch who incorporated parents into their child's treatment (Guerney, 1964). Freud (1959) in "An Analysis of a Phobia in a Five-year-Old Boy" gave therapeutic instructions to the child's father and allowed the father to carry out treatment in the home. According to Freud: "The treatment itself was carried out by the child's father…No one else could possibly have prevailed on the child to make such avowals; the special knowledge by means of which he was able to interpret the remarks made by his…son was indispensable" (p. 149).

Moustakas (1959) suggested that parents of normal children conduct in-home play sessions with their children in order to facilitate positive interactions and experiences. Moustakas referred to these in-home play experiences as "relationship therapy" and perceived such play sessions as emotionally therapeutic for the child (Moustakas, 1959). According to Moustakas, "Through the process of self-expression and exploration within a significant relationship, through realization of the value within, the child comes to be a positive, self-determining, and self-actualizing individual" (p. 5). Fuchs (1957) began in-home play sessions with her daughter at the encouragement of her father, Carl Rogers, when the child was experiencing emotional distress due to toilet training. Fuchs reported that the in-home plays sessions lead to remarkable results and an extinction of toileting difficulties. Baruch (1949) viewed in-home play sessions as a way to foster healthy parent-child relationships with interactions between the parent and child modeled after

Axline (1947). Axline postulated that in-home play sessions allowed the child to work through their issues while enhancing the parent-child relationship (Landreth & 2006) in a Rogerian client-centered manner (Guerney, 1964). The in-home play sessions indicated by Freud, Moustakas, Fuchs, and Baruch did not involve close instruction or supervision by a therapist, nor were they conducted in a group therapy or support group design, nevertheless, positive outcomes were reported (Landreth, 1991). As a result, Guerney regarded these favorable experiences as promising and used the family focused play sessions in his model of Filial Therapy (Guerney, 1964).

Guerney's Filial Therapy model incorporated child-centered support in the form of in-home play session between the parent and the child (Guerney, 1964). According to Guerney, Guerney, and Androcio (1966), parents were taught the following tenants and instructed to utilize them in play sessions: 1) parents must be empathic and make every effort to understand how the child views themselves and their world; 2) the parent must be fully accepting of the child's feelings and thoughts; 3) the parent must leave the direction of the play sessions to the child; and 4) the parent must convey to the child that they understand and accept him or her. Parents were also taught to avoid giving their children directions, suggestions, or advice during their in-home play sessions and to avoid evaluating or making judgments of the child's play (Guerney, 1978). In this manner, the parent, rather than a therapist, became the agent of change in the child's life (Landreth, 1991).

Guerney's model of Filial Therapy not only allowed parents to be trained and supported by therapists, but also allowed parents the opportunity to discuss and process their experiences in a group setting (Guerney, 1964). Through instruction, modeling,

demonstrations, group practice and homework assignments, parents could now capitalize on building resources to aid in the development of the parent-child relationship (Landreth & Bratton, 2006). These didactic elements set Filial Therapy apart from other psychological interventions of the time (Landreth, 1991).

Guerney, his wife Louise Guerney and his protégés researched Filial Therapy in an attempt to evaluate the effectiveness of his approach to parent training (Landreth & Bratton, 2006). The initial Filial Therapy study was conducted by Stover and Guerney (1967) utilizing an experimental group format with a sample of 28 mothers who sought intervention with their children. Outcome data indicated that mothers in the Filial Therapy group were not only able to conduct child-centered play sessions, but were also able to reduce directive behavior with their children, increase reflective statements and empathic listening, and set therapeutic limits with their children (Stover & Guerney, 1967). Some criticism resulted regarding this research study due to the lack of a control group.

Stover and Guerney (1971) were able to support the findings of their previous research with a landmark study that involved severely emotionally disturbed children and their parents. In an experimental group, control group research format, 51 parent and child dyads participated in 12 months of Filial Therapy training. Outcome data indicated that parents involved in this study were also able to conduct play sessions in a child-centered manner and were able to increase their ability to respond to their children empathically through reflective statements, as well as set therapeutic limits. In addition, assessments completed by both parents and clinicians indicated that all 51 children had improved in some capacity. Twenty-eight of the children's symptoms and psychosocial

adjustment were viewed as being very much improved and no child was viewed as staying the same or de-compensating. Other benefits to participants included increased interactions between parent and child, play sessions as an appropriate outlet for feelings of anger and aggression, authentic sharing and conversation between parent and child, and decreased dependency toward the parent.

Louise Guerney (1975) conducted a longitudinal investigation of the study implemented by Guerney and Stover in 1971. Participants of the Guerney and Stover study were interviewed between one and three years later to determine the continued efficacy of the filial Therapy intervention. The 51 participants in the previous study were surveyed and 42 out of 51 responded. Only one of the 42 respondents indicated that they had sought further treatment for their child and 32 of the respondents indicated that their children continued to improve. Sixty-four percent of the parents who viewed their children as improved indicated that their child's progress was based on the parent's increased ability to relate to their child in an appropriate and positive manner. Overall, the parents surveyed evaluated the Filial Therapy training as a positive experience for themselves and their child. This longitudinal follow-up investigation suggested that benefits derived from Filial Therapy were evident up to three years subsequent to the initial intervention (Guerney, 1975).

Sywulak (1977) examined the differences of Stover and Guerney's Filial Therapy study when both a treatment group and a control group were utilized. Participants included 13 mother and father pairs and six single mothers. The parents completed an assessment related to their child's behavior and adjustment four months prior to training, at the mid-point of training, and four months subsequent to the training. The data

obtained from this study showed a decrease in parental reports of problematic behavior and significant improvement in parental acceptance. Other findings included parents being willing and able to implement Filial Therapy techniques, withdrawn children exhibiting changes more expeditiously than aggressive children, and that fathers noticed change in adjustment later than mothers.

These early studies indicated that Filial Therapy offered parents a therapeutic alternative. Parents had the opportunity to address the difficulties of parenting in a supportive group environment and were able to be instrumental in their own child's treatment. This pioneer research conducted by Bernard Guerney, Louise Guerney, and their protégés provided the basis for the Landreth model of Filial Therapy, Child-Parent-Relationship Therapy (Landreth and Bratton, 2006).

The Landreth Model

Garry Landreth further refined Filial Therapy in the 1980s when he developed Child-Parent-Relationship Therapy, a 10-session model of Filial Therapy (Landreth, 2002). Because parents were not familiar with the term Filial Therapy, Landreth marketed his program as C-P-R Training, which later became Child Parent Relationship Therapy (CPRT) (p. 232). This model of Filial Therapy incorporated a time-limited approach to Filial Therapy in an attempt to make treatment more available to families who could not afford long-term treatment and to decrease the likelihood of early termination of services (Landreth, 2002; Landreth & Bratton, 2006). Landreth developed a specific treatment protocol that gave explicit instructions for teaching CPRT techniques and for implementing and facilitating training and group process (Landreth & Bratton, 2006).

Child Parent Relationship Therapy is one of the most often examined treatment methods in the field of child psychotherapy (Landreth & Bratton, 2006). Over 800 subjects in 33 studies have been involved in investigating the efficacy of this treatment option. The focus for evaluating the effectiveness of CPRT centers on the following: 1) changes in parents that resulted from the intervention; 2) changes in children that resulted from the intervention; 3) the long term effects of Filial Therapy; and 4) the effectiveness of CPRT with special populations (Landreth & Bratton, 2006).

Filial Therapy Literature

Glazer and Kottman (1994) utilized a case study format to examine the effectiveness of CPRT as an intervention when the relationship between a parent and child was altered as a result of divorce. The father had supervised visitation and limited contact with his daughter over a two-year period of time. The father was instructed in client-centered communication strategies, active listening, and therapeutic limit setting skills. The investigators then supervised ten 30-minute play sessions between the father and his daughter. The investigators reported that Filial Therapy changed several aspects of the relationship between the parent and child. Physical contact increased between the two, as did the content of their verbal interactions. The child included her father in her play over time, indicating trust and intimacy. The father reported being able to allow his daughter to lead the play sessions and became adept at using self-esteem building responses. The investigators indicated that the daughter's fear of abandonment decreased and both the father and his daughter viewed the time they spent in therapy as very special. A secondary benefit was reported by the child's step-mother who indicated an improved relationship with her step-daughter subsequent to the intervention.

Bratton, Ray, and Moffett (1998) conducted a case study whereby CPRT was initiated with custodial grandparents and their grandchildren. CPRT was reported to be the vehicle for providing stability and emotional support to the grand children who had been placed with their grandparents as a result of abuse and neglect. Positive changes subsequent to the CPRT intervention included improved family interactions, the development of problem-solving techniques, a much closer sibling relationship between the children, improvements in the children's behavior and increased attachment between the grandparents and their grandchildren. Two months after treatment, follow up indicated that the grandparents continued to have play sessions with their grandchildren and those behavioral problems continued to improve.

Bratton and Landreth (1994) attempted to determine the effectiveness of CPRT with single parents. Using an experimental group, control group format that incorporated the Porter Parental Acceptance Scale (PPAS) and the Filial Problems Checklist (FPC) as measurement instruments, the single parents in the CPRT group demonstrated a significant increase ($p>.05$) in their ability to respond empathically to their children. In addition, the experimental group parents exhibited a significant increase ($p>.05$) in their ability to respond to their child's feelings and the expression of those feelings as well as an increased ability to exhibit unconditional love, and recognize the child's need for autonomy. A significant decrease ($p<.05$) in parental stress related to parenting and a reduced report of behavioral problems were also reported by the parents in the experimental group.

Landreth and Lobaugh (1998) examined the effectiveness of Filial Therapy under extreme conditions. Their research determined that incarcerated fathers were much like

fathers outside of prison as they cared for their children and were eager to improve interactions with them. Even fathers with a history of violence were reported to be able to learn new ways to interact with their children. The investigators used the Child Behavior Checklist (CBCL), the Porter Parental Acceptance Scale (PPAS), and the Parental Stress Index (PSI) as measurement tools in a pre-test, post-test format. Subsequent to this study, researchers found a significant difference ($p > .05$) in the fathers who were better able to: 1) cope with stress, 2) adjust to their incarceration, 3) accept their child, and 4) empathically respond to their child. Subsequent to the 10-week intervention, statistical data indicated that the children's self-concept had significantly improved ($p > .05$) based on this 30 minute per week intervention with their fathers.

This study was then replicated with a group of mothers who were also incarcerated. Harris and Landreth (1997) modified the above mentioned Filial Therapy intervention by condensing it into a five-week model. The researchers attempted to determine whether or not they could speed up the emotional development of the children as well as the emotional growth and stability of the parents through a five-week program. The time frame used was the only procedural modification. Incarcerated mothers received training for a two hour period twice a week for five weeks. They then had play sessions with their children twice a week for a five-week period. The researchers found similar results between the two studies. Incarcerated mothers also showed better coping skills and increased empathy and acceptance of their children following the intervention. The children of incarcerated mothers also showed an increase in self-concept as a result of involvement in the research.

Costas and Landreth (1999) researched the efficacy of CPRT with non-offending parents and their children who had been affected by child sexual abuse. The investigators used the PPAS, the PSI, the CBCL, the Child Anxiety Scale (CAS), the Joseph Pre-School and Primary Self-Concept screening Test (JPPCST) and the Draw a Person: Screening Procedure for Emotional Disturbance (DAP:SPED) as measurement tools in this pre-test, post-test, experimental group, control group designed format. The results of this study indicated that the non-offending parents in the experimental group significantly increased ($p > .05$) their level of empathy and acceptance for their children. Other benefits included a significant decrease ($p < .05$) in the level of stress experienced by the parents in the experimental group. The children in the experimental group showed improved behaviors, self-concept, and emotional adjustment as well as a decrease in anxiety. This study indicated that families with abuse histories benefited from CPRT.

In an attempt to determine if CPRT was an effective intervention for parents of children with learning difficulties, Kale & Landreth (2000) initiated this research study. A pre-test, post-test, experimental group, control group method was utilized with the PSI and the PPAS as measurement instruments. Subsequent to the study, the experimental group significantly increased their level of acceptance for their children ($p > .05$) and significantly decreased ($p < .05$) their stress level in regard to parenting.

Tew, Landreth, Joiner and Solt (2002), investigated the effects of CPRT with children and parents who are chronically ill. This quantitative study used the PSI, PPAS, and the CBCL as measurement tools in experimental and control groups to determine the effectiveness of CPRT with this sample. Findings included a significant reduction in the stress of the CPRT group ($p < .05$) related to parenting and in the parent's perception of

the children's problematic behaviors. In addition, a significant increase in parental acceptance was also reported.

Filial Therapy was found to be an effective method of improving the relationship between parents and children and grandparents and their grandchildren. Filial Therapy was also conducted with cultural groups to determine its cross- cultural effectiveness.

Filial Therapy with Cultural Groups

Filial Therapy has been conducted with a wide variety of cultures. These include studies with different ethic groups, and non-traditional family structures. The following Filial Therapy research studies were found to result in some form of benefits to all samples examined (Chau and Landreth, 1997; Yuen, Landreth, & Baggerly, 2002; Jang (2002); Glover and Landreth, 2002).

Chau and Landreth (1997) examined the effectiveness of Filial Therapy with a group of Chinese immigrants. Thirty-six new Chinese immigrants participated in the Landreth 10-week Filial Therapy model of training, group process, and play interventions with their children. Subsequent to the Filial Therapy intervention, parents reported an increase in empathic interactions between themselves and their children and an increase in acceptance of their children. In addition, participants reported a reduction in stress related to parenting their children.

This study was replicated in 2002 with Chinese immigrants in Canada (Yuen, Landreth, & Baggerly, 2002). Thirty-five Chinese immigrants with children between the ages of two to ten years of age participated in this research study using the same 10-week Filial Therapy-training model previously described. The findings were consistent with the

finding from the first study, but in addition, parents reported a reduction of perceived problems related to their children's behavior and an increase in their child's self-concept.

Jang (2002) evaluated the efficacy of Filial Therapy with Korean Parents utilizing the PSI, PPAS, FPC, and MEACI as measurement instruments. Jang also used the pre-test, post-test control group design but added parent interviews in his research study. The finding of this study indicated a significant increase in empathic interactions between parents and their children and a significant reduction in the children's problematic behaviors. According to findings from parental interviews, other family benefits resulted as well. These benefits included mothers reporting increased sensitivity to their children, and improved communication between couples.

Glover and Landreth (2002) examined the effectiveness of Filial Therapy with Native American families living on the Flathead Reservation. The study utilized a pretest, post-test control group design and the PSI and PPAS as measurement tools. Following treatment, participants indicated improved communication between their children and improved relationships with other family members. Participants further indicated an increase in the level of empathic interactions with their children and an increased level of desirable play behaviors between children and their parents. Although all 21 parents indicated these positive trends, they did not reach statistical significance.

Summary of Filial Therapy Literature

Filial therapy is a treatment option with the goal of facilitating a positive relationship between a parent and child and to facilitate the elimination of the child's behavioral problems (Watts & Broaddus, 2002). Filial therapy allows parents to become change agents by creating a non-judgmental, accepting and understanding environment in

which the parent-child relationship can develop (Landreth, 2002), which results in personal growth for both the parent and the child (Landreth & Bratton, 2006).

Outcome studies support the efficacy of Filial Therapy and the CPRT model of Filial Therapy between parents and their children in various settings, across age, gender, marital status, and cultural and ethnic groups (Guerney, 1991; Glazer & Kottman, 1994; Van Fleet, 1994; Bratton & Landreth, 1994; Chau & Landreth, 1997; Harris & Landreth, 1997; Bratton, Ray, & Moffit, 1998; Landreth & Lobaugh, 1998; Glover & Landreth, 2000; Jang, 2002; Landreth, 2002; Watts & Broaddus, 2002; Yuen, Landreth, & Baggerly, 2002; Bratton, Ray, Rhine, & Jones, 2005; Landreth & Bratton, 2006). Filial Therapy is empirically validated by large effect sizes, single-participant research, and case studies, and has been applied to many different kinds of problems and across populations with positive outcomes for children and families (Bratton et al., 2005). It is logical to believe that this intervention is worth considering as a therapeutic intervention to decrease behaviors typically associated with attachment difficulties in foster children with attachment problems.

Attachment Theory

Attachment Theory offered the most significant account of the child-caregiver relationship and its affect on the child's development and outcome (Fairchild, 2006). Attachment Theory proposed that children are biologically predisposed to seek and form attachments to their primary caregivers through an "attachment behavioral system" (Bowlby, 1969). This attachment behavioral system ensures the child's survival and protection as the child attempts to seek and maintain close proximity to the attachment

figure, who will meet both the physical and psychological needs of the child (Bowlby, 1988).

Attachment Theory was first formulated by John Bowlby, a British psychiatrist, psychoanalyst, and researcher, who studied the relationship between children and their mothers. Bowlby chose the mother-child relationship because of its generality, in effect, the mother-child relationship was found across cultures and species (Bowlby, 1969). Three major theoretical constructs were involved in attachment theory: 1) the role of attachment behaviors; 2) the concept of internal working models; and 3) the concept of a secure base. Attachment theory has evolved into one of the most well researched theories of human development in the field of developmental and social psychology and includes social, behavioral, emotional, and cognitive components (Fairchild, 2006).

According to Bowlby (1969), Attachment Theory was a way to conceptualize the tendency of human beings to make strong affectional bonds with significant others. Bowlby defined attachment behaviors as ‘‘any form of behavior that results in a person attaining or maintaining proximity to some other clearly identified and preferred individual who is conceived as better able to cope with the world’’ (Bowlby, 1969, p.27). Such attachment behaviors were considered instinctive and resulted when the right conditions were met and were not formed on the basis of generalized dependency needs. Bowlby hypothesized that such attachment behaviors existed across the life span and were not bonds that children outgrew over time. Furthermore, attachments were formed to certain individuals who were chosen according to the child’s order of preference and endured and become supplemented by new bonds as the child developed.

Bowlby further hypothesized that there were two functions for attachment figures (Bowlby, 1988). First, the attachment figure provided the biological function of protection necessary for survival, and second, the attachment figure provided the psychological purpose of security. These two functions offered the child a "Secure Base" and were instrumental in the development of secure attachments between the child and his or her caregiver (Bowlby, 1988). Behaviors on the part of the child further indicated whether or not an attachment relationship existed: 1) the child indicated a desire to be with the attachment figure; 2) the child sought the attachment figure when stressed; 3) the child derived comfort from the attachment figure subsequent to the stressor; and 4) the child protested if the attachment figure is not available (Bowlby, 1969). In order for a secure attachment to occur, the child must experience a caregiver who is responsive to him or her during life events such as feeding, playing and comforting in times of stress. In addition, the caregiver must be sensitive to the child, in effect, responding to the child's verbal and nonverbal cues. According to Bowlby (1969) if the child's primary attachment figure does not respond to the child in such a manner, he or she will first go through a stage of protest, followed by a stage of despair, and finally, will detach from the primary attachment figure.

Central to Attachment Theory is the concept of internal working models (Bowlby, 1969). Through interactions with the attachment figure, the child developed internal representations of self and others. These internal representations included beliefs and expectations about the responsiveness of the attachment figure, the level of caring exhibited by the attachment figure, and internal beliefs regarding the child's worthiness of care and attention (Pearce & Pezzot-Pearce, 2001). If the attachment figure is

emotionally available and supportive, the child might internalize a model of self as valued and competent. If the attachment figure is rejecting, unavailable, or unresponsive, the child may internalize a model of self as devalued and incompetent. According to Bowlby (1972), mental health is intricately entwined with the quality of relationships with attachment figures from infancy throughout the lifespan. Bowlby stated:

> For not only young children, it is now clear, but human beings of all ages are found to be at their happiest and to be able to deploy their talents to best advantage when they are confident that, standing behind them, there are one or more trusted persons who will come to their aid should difficulties arise. The person trusted provides a secure base from which his companion operates. (p. 359)

In addition, the primary attachment relationship is perceived as the most influential in shaping internalized working models (Pearce & Pezzot-Pearce, 2001). To better understand primary attachment relationships, Ainsworth, Blehar, Waters, and Wall, (1978) developed a methodology and classification for attachment behaviors and patterns between children and their primary caregivers in a landmark research study called, "The Strange Situation."

The objective of this research was to determine the quality of attachment relationships by objectively observing a child's reaction when separated from his or her mother as compared to the child's reaction when separated from a stranger (Ainsworth, Blehar, Waters, & Wall, 1978). The researchers filmed and rated each child's level of security or insecurity based on the child's response to being left by the mother and then the response to the mother upon her return.

According to Ainsworth, Blehar, Waters, and Wall (1978), three distinct patterns were identified in relation to the children's responses:

- Securely attached - the child was distressed and protested when separated from the mother, then turned to greet the mother upon her return in an attempt to regain closeness. The child sought comfort and then resumed playing.
- Insecure-Avoidant attached - the child showed little distress to the mother's leaving and no particular reaction upon her return, especially when she came back for the second time. The child appeared to actively avoid the mother's attempts to regain contact. Such behaviors resembled rejection. The child would continually observe the mother; consequently, their play was inhibited.
- Insecure-Ambivalent attached - the child was very distressed by the mother leaving and was difficult to comfort. The child tended to express a need for comfort but would react with anger when it was provided. The child engaged in preoccupation with the mother and would alternate between seeking comfort and rejecting behavior. The child's play was inhibited.

The behavior of the mothers involved in the study tended to mirror the children's responses to the Strange Situation. Mothers of Securely attached children were highly responsive to their children while the mothers of the Insecure-Avoidant children were unresponsive to their children, and the mothers of the Insecure-Ambivalent children behaved inconsistently towards their children. The patterns identified in this research

study are now viewed as diagnostic instruments to assess the level of attachment between caregiver and child and have been used for many years in countries throughout the world as a recognized and valid means of description (Green & Scholes, 2004). Later, a pattern of Insecure-Disorganized attached was added to the list of attachment patterns first proposed by Ainsworth (Green & Scholes, 2004). Children with an Insecure-Disorganized attachment responded in a confused, unpredictable, and disorganized manner when separated from their attachment figure (Hardy, 2007). Conflicted behaviors were exhibited by the child, for example, reaching for the caregiver and then turning away simultaneously. Hardy postulated that this appeared to be related to internal conflict between the attachment figure being both the cause of the distress and, at the same time, the only source of comfort for the child. According to Main (1996), the Disorganized attachment style is most correlated with psychopathology.

Attachment Theory and Abuse and Neglect

A major tenant of Attachment Theory was the belief that variations in early caregiver to child interactions leads to differences in attachment security (Gray, 2002). Factors influencing the attachment process included characteristics of the child, such as the child's temperament and level of irritability (Brisch, 2002; Santrock 2008). Parental factors, such as substance abuse, the parent's own attachment issues, intellectual capacity, and behavioral patterns play also played a significant role in the attachment process (Brisch, 2002). Social influences, such as the home environment, exposure to violence, maltreatment, social support system available to the parent, and the quality or lack of a marital relationship all affected the attachment patterns (Gray, 2002). Life events, such as divorce, illness, relocation, death, trauma, and removal from the family of

origin all played a significant part in the development of attachment patterns (Santrock, 2008). Even children that once experienced secure attachments had the potential to become insecurely attached when exposed to such risk factors (Gray, 2002).

Care giving that was non-responsive was reported to lead to Avoidant attachments and care giving that was inconsistent or unreliable was reported to lead to Ambivalent and Resistant attachment (Ainsworth, Blehar, Waters, & Walls, 1978). Furthermore, Disorganized and Disoriented attachments appear to be a result of confusion and fear towards the caregiver and conflict related to whether or not the child should attempt to maintain contact with the caregiver in times of stress (Green & Scholes, 2004). According to Hardy (2007) such Disorganized and Disoriented attachment patterns are typical seen in children who have been maltreated by their attachment figure.

Since maltreated children often experience abandonment and disturbed parent-child relationships, they are likely to develop abnormal emotional, linguistic, and cognitive development (Eagle, 1994; Silver, Amster, & Haecker, 1999). Maladaptive attachments may precipitate feelings of mistrust and rage which often results in the child's failure to develop a conscience (Levy & Orlans, 1998). In addition, maltreated children are at risk for emotional withdrawal, denial of negative feelings, and flattened affect and as a result, lack the cognitive and emotional abilities or resources to cope with stressors (Eagle, 1994). Behavioral manifestations of maladaptive attachment include antisocial behavior such as fire starting, sexual molestation, animal abuse, as well as the inability to accept or reciprocate affection (Levy & Orlans, 1998).

Attachment and Antisocial Behavior

Does attachment play a role in the child's ability to develop moral reasoning or to avoid antisocial behavior? Ijzendoorn (1997) described evidence that the beginning of morality, which is the ability to have empathic feelings for the distress of another or to comply with caregiver requests, is closely linked to the developing relationship with a primary attachment figure. Insecure attachment and attachment disorders may be at the root of antisocial, aggressive and delinquent behaviors throughout the life span (Levy & Orlans, 1998; Green & Scholes, 2004).

Three hypotheses have emerged regarding the affects of individual differences on the development of morality (Ijzendoorn, 1997). First, it is believed that genetics play a role in the development of empathy, or a lack thereof (Bowlby, 1969). Second, parental child rearing practices in the form of discipline further determine the development of empathy (Ijzendoorn, 1997). If the parent is viewed by the child as warm and loving but strictly and consistently forbids harmful behaviors to others, the child will develop empathy. If the parent does not behave in this manner, empathy for others will not develop (Brisch, 2002). Third, moral development is considered to be a direct result of attachment relationships with a parent or parent figure (Ijzendoorn, 1997). Children with Secure attachments are more likely to become empathic to others and internalize parental norms; however, children with Insecure attachments may be less empathic and less likely to internalize parental norms (Gray, 2002). Moreover, a parent that uses authoritarian control combined with treats of the withdrawal of love will likely facilitate the child's compliance (Santrock, 2008), but will inhibit moral internalization (Izendoorn, 1997).

Children with attachment difficulties have been reported to exhibit behaviors that prove problematic for the parent, the child, and society as a whole (Randolph, 2000). According to Randolph, children with attachment difficulties resulting from Avoidant, Anxious, Ambivalent, or Disorganized attachment formation may exhibit the following behaviors: 1) superficially and engaging; charming behavior, 2) indiscriminately affectionate behavior with strangers; 3) destructive to self, others, and possessions; 4) developmental lags; 5) lack of eye contact; 6) lack of demonstrative behavior with caregivers; 7) cruelty to animals, siblings or others; 8) lack of cause and effect thinking; 9) poor peer relationships; 10) inappropriately demanding or clinging; 11) engaging in stealing or lying behavior,;12) lack of age appropriate-guilt; 13) engaging in persistent nonsense questions, incessant chatter, or arguing; 14) abnormal speech patterns; 15) poor impulse control; 16) controlling behavior; 17) does not learn from consequences; 18) makes false accusations; 19) will not allow caregivers to comfort him or her; 20) sneaks things, even though he or she could have them if he or she had asked; 21) can't keep friends for more than a week; 22) throws tantrums; 23) accident prone; 24) doesn't do well in school, but could do well if he or she put forth effort; 25) sets fires or is preoccupied with fire; 26) prefers violent shows or movies; 27) engages in hording or gorging on food; 28) engages in risk taking behavior; 29) repressed rage; and 30) high pain tolerance.

Summary of Attachment Literature

According to Attachment Theory, attachment is established based on the interactions between a child and their primary caretaker (Bowlby, 1969). The quality of the attachment is further established based on the characteristics of the parent and child as

both the child and the caregiver influence the attachment process. The child's temperament and level of irritability are direct contributors to the attachment progression. Characteristics of the parent, including substance abuse, intellectual capacity, behavioral patterns, and their own attachment issues also have a direct impact on the quality of the attachment relationship (Brisch, 2002).

Deprivation of attachment leads to a wide range of anti-social and developmental difficulties and attachment security is the basis for understanding a child's risk for the development of maladaption and psychopathology (Main, 1996). Variations in parental interactions with the child lead to differences in attachment security, i.e., when a caregiver is non-responsive, the child will develop an Avoidant attachment and when the parent is inconsistent or unreliable care giving leads to Ambivalent, Resistant, and Disorganized attachments (Ainsworth, Blehar, Waters, & Wall, 1978).

Social influences and life events impact attachment as well (Levy & Orlans, 1998). The home environment, exposure to violence and maltreatment, the social support system available to the parent as well as the quality or lack of a martial relationship all contribute to the child's ability to attach to his or her caregiver (Gray, 2002). Life events such as divorce, illness, relocation, death, trauma, and removal from the family of origin may affect attachment as well. Furthermore, even secure attachments can change to insecure attachments based on life events (Brisch, 2002). What happens to a child when attachment difficulties are exacerbated by the social contact in which they live?

Children in Foster Care

In 2006, approximately 905,000 children were victims of child abuse or neglect in the United States and 510,000 of those children were placed in the child welfare system's

foster care program (United States Department of Health and Human Services, Children's Bureau, 2008). The placement of children in foster care is typically a result of child abuse and neglect and children from low socio-economic and single parent families are most often at risk (Palmer, 1996). Although the child welfare system emphasizes preventing children from entering the foster care system and maintaining familial relationships when possible, many children will spend a substantial portion of their childhood in foster care (Mason et al., 2003). According to the Adoption and Foster Care Analysis and Reporting System Report of 2008, 22 percent of the above mentioned children had been in foster care for one to two years, 12 per cent had been in care for two to three years, 11 per cent had been in care for three to four years, and 13 percent had been in care for five years or more (United States Department of Health and Human Services, 2008). Involvement in the child welfare system and placement in foster care has the potential to dramatically impact a child's outcome.

Few empirical studies exist that have examined the factors associated with the outcomes of children placed in foster care (Mason et al., 2003). Findings from the existing studies offer mixed results in effect, some studies indicate that children in foster care show improvements in health, emotional adjustment, behavioral functioning, and in school performance as a result of their involvement in foster care (Behalf & Wade, 1996; George, Wulczyn, & Fanshel, 1994). Other studies offer an entirely different picture, in effect, that foster children are at greater risk for mental health disorders, involvement in the criminal justice system and for employment difficulties (Atkinson & Zucker, 1997; Minde, 2003). Involvement in the foster care system alone imposes further vulnerabilities upon the child including physical, social, and emotional difficulties that can result from

disrupted attachments (Silver, Amster, & Haecker, 1999). Understanding foster children from an attachment perspective is critical if social service agencies and mental health professionals are to meet their needs and facilitate positive outcome.

Foster Children and Attachment

It is likely that children who have been placed in foster care have experienced attachment disruption to some degree. The physical removal from one's family of origin is significant and further complicated by the factors that precipitated the removal such as abuse, neglect, and exposure to parental substance abuse. In an attempt to determine the association of maltreatment and attachment style, Egeland and Sroufe (1981) conducted a study with very young children using Ainsworth's "Strange Situation". Thirty-one extremely abused and or neglected children who had inadequate care were assessed at 12 months and 18 months and compared with 33 infants from the same low socioeconomic status that had a history of excellent care. At the 12- month assessment, the extremely abused and neglected children were less secure than the children who had received excellent care ($n = 64; p = .008$). However, at the 18th month no significant difference was reported between the two groups in regard to attachment ($n=64; p = .29$).

Attachment of the group associated with excellent care was stable throughout the assessment period (Egeland & Sroufe, 1981). The children in the inadequate care group who had experienced extreme abuse and neglect had a significantly greater change in attachment ($n = 64; p < .05$) and had moved into the securely attached range. It was determined that the resulting secure attachments of the inadequate care group were not related to the type of social services this group received or to the duration of those services. Changes in attachment status appeared to be related to a supportive family

member within the family structure, a decrease in chaotic lifestyle, and the resiliency of certain infants.

A subsequent study conducted by Lamb et al. (1985) supported the finding of Egeland and Sroufe (1981). Thirty- two abused and or neglected children and their biological or foster parents were assessed using the strange situation. The children were all from low socioeconomic backgrounds and were referred by Child Protective Services. They included those who were abused by one or more of their parents and those who had been abused by someone other than a parent. The maltreated group of children was compared to children from similar backgrounds that lived with one or both biological parents and had no history of abuse or neglect. Individuals who were not familiar with the children or their status rated the video tapes of the "Strange Situation" and coded all responses utilizing Ainsworth's attachment security classification.

Results indicated that most of the maltreated children exhibited Insecure-Avoidant attachment styles which occurred whether or not the child was living with their biological parent or were living in foster care (Lamb et al., 1985). Additional results indicated that seven out of the nine children who were abused by someone other than a parent exhibited secure attachment style. This finding suggests that despite maltreatment by others, a child can develop a Secure attachment if the parent exhibits attachment behavior towards the child. Of further interest is the finding that there was no relationship between attachment styles and the frequency or length of placement in foster care. Nor were there significant differences related to the type of maltreatment experienced by the child or the age of the child.

In an attempt to examine the outcome of children placed in foster care, Fein, Maluccio, Hamilton and Ward (1983) conducted a longitudinal study of 187 children who had been discharged from foster care after at least a 30 day period of time. Fifty-three percent of the children involved in the study had been returned to their family of origin, while others were adopted, living with relatives in kinship placements, or were placed in foster-adopt homes. Data were collected through case histories and through extensive interviews with parents, relatives and foster parents. Measures of family adjustment, emotional and developmental functioning, overall behavior, and school performance were compared to the age of the child and the type of home the child lived in using a multiple regression analysis. Results indicated that most of the 187 children who had been in foster care were doing adequately or moderately well in all areas after being placed in their permanent homes.

Marcus (1991) attempted to determine the attachment style of children in foster care and the relationship between children's level of attachment and their adjustment to the foster care system. Marcus used the Achenbach Child Behavior Checklist, the Parent Child Reunion Inventory and foster care worker's perceptions of the child's emotional attachment to biological and foster parents to determine the child's attachment style. The Interpersonal Reactivity Index was used to measure the child's ability to be empathic to others. The *.01* alpha level was employed to yield a significant correlation between the foster child's achievement problems and attachment to the foster mother and with physical affection demonstrated by the foster father. Internalizing behavior was correlated to the quality of attachment to both the foster mother and foster father with externalizing behavior being moderately associated with insecure attachment to the foster

mother and foster father. A one-way ANOVA was used to assess the foster care worker's perceptions of the child's emotional attachment to the biological parents and foster parents. Findings indicated that the foster children were least attached to their biological fathers and were significantly attached to their biological and foster mothers, though more attached to their foster parents than to their biological parents. In addition, the longer the child was in foster placement, the greater the attachment to the foster parents. No correlation was found to exist between the age of the child and their attachment to the foster parents. However, the longer the child was in foster care, the less attached they became to their biological mothers and the more attached they became to their biological fathers, although participants had little contact with their fathers. The authors suggested that the child's view of the biological father became more idealized with time in foster care and with the diminishing attachment to the biological mother (Marcus, 1991).

In summary, research studies that measure issues related to attachment and foster children are limited and dated. In addition, the available research is further restricted by inconsistent definitions of attachment and limitations in research designed based on the use of non-standardized assessment instruments (Klassen, 2000). Nevertheless, the information provided by available studies offers some insight into the attachment styles of foster children, their ability to form attachments with biological and foster parents, and factors that influence such attachments. How does a child that has been deprived of healthy attachment experiences learn to develop such a connection?

Attachment Interventions

Professionals within the mental health, child welfare, school, and court systems are increasing becoming aware of the vast role that attachment plays in the lives of

children and society as a whole (Brazeale, 2001). The increase of children with severe attachment problems has been characterized as a societal concern that should garner our immediate attention (Parker & Forrest, 1993). Even the most dedicated parents and foster parents often find it difficult to parent children with attachment issues (Gray, 2000).

DSM IV – TR Classification

Attachment difficulties present themselves on a continuum between mild to severe. Only Reactive Attachment Disorder (RAD) of infancy or early childhood is associated with pathology in attachment and is reserved for the most severe cases (Boris, 2005). According to the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition- Text Revision* (DSM IV- TR) (American Psychiatric Association, 2000), RAD is defined as "a pattern of disturbed and developmentally inappropriate social relationships that present prior to age five, a history of pathogenic care that occurs before the presentation of the disturbances, and the assumption that the disturbances are not better accounted for by other diagnoses" (p. 130).

Two subtypes of RAD are also listed in the DSM IV - TR, the Inhibited type and Disinhibited type. A pattern of the Inhibited type of RAD may occur when children do not receive needed comfort and support from their primary attachment figures (Hardy, 2007). Because the child expects to be rejected, they may be awkward in social settings, avoid social contact, may be withdrawn and avoid comforting support from others (Hardy, 2007). A pattern of the Disinhibited type of RAD may occur when children have an unresponsive caregiver who can be coerced into providing needed affection (Haugaard & Hazan, 2004). As a result, the child learns to exhibit such behaviors as an exaggerated

need for assistance, inappropriate childishness, comfort seeking from strangers, and inappropriate familiarity.

RAD is not conceptualized as a relationship specific disorder, rather as a disorder of relatedness that occurs within the child and that is expressed across all relationships (Luby, 2006). The RAD diagnosis appears most applicable to young children and its appearance in older children and adolescents can be mistaken for other disorders (Zilberstein, 2006). Data concerning the prevalence of RAD are limited; however, existing data suggest that the frequency of RAD is less than one percent (Boris, 2005). Although the prevalence of RAD is unknown, Zeanah et al. (2004) identified the incidence of RAD among high-risk toddlers in foster care to be between 38 and 40%.

Interventions

Theories that explore the etiology of attachment difficulties include the absence of a primary attachment relationship (Bowlby, 1969), maltreatment (Levy & Orlans, 1998), characteristics of the child or the parent (Brisch, 2002), social events (Gray, 2002), genetic factors (Ijzendoorn, 1997), and life events (Gray, 2002). An important question in research pertaining to attachment intervention is: "What works for whom", as there is little support for one treatment modality that works for everyone (Eagle, 1994). Two common approaches to treating children and families affected by attachment difficulties include psychoeducational treatment and psychotherapy. The focus of psychoeducational treatment is to increase parent's knowledge of child development, facilitate relationship development between the parent and child, and to teach coping and self-care skills (Cornell & Hamrin, 2008). The underlying assumption is that improved relationships between the parent and child will result when parents are presented with educational

information and support. Psychotherapy as a treatment modality focuses on improving the attachment relationship between the parent and child by changing maladaptive internal representations (Cornell & Hamrin, 2008).

Psychoeducational Treatment

Psychoeducational treatment for attachment issues may involve the parent directly and the child indirectly, however, some programs included both the parent and the child. Psychoeducational treatment is conducted by a therapist who trains parents in basic child development, parenting skills such as soothing behavior, responding to the child's social cues, engaging a withdrawn child, and reciprocating the child's overtures of engagement (Carmen, 1994). Interventions may be focused around child management strategies or education of the child's difficulties so that parents or caregivers do not personalize the child's negative behaviors (Pearce and Pezzot-Pearce, 2002).

Mukkades, Kaynak, Kinali, Besikci, & Issever (2004) conducted a short term psychoeducational intervention with children diagnosed with Reactive Attachment Disorder and autism and their parents in an attempt to enhance attachment relationships, improve social interaction, self-care, language and cognition, and fine and gross motor skills. Three months of weekly interventions incorporated didactic and experiential activities to enhance interaction between parent and child and to improve communication. In addition, the parents were trained in effective parenting and educated regarding their child's diagnosis. Findings of this study indicated that the children diagnosed with reactive attachment disorder showed significant improvement in all areas as opposed to the children diagnosed with autism. In addition, the authors indicated that parents were reported to be highly motivated to use the new skills developed from this intervention.

Mukkades, Bilge, Alyanak, and Kora (2000) also implemented a research study with 15 parents of toddlers that had been diagnosed with RAD. The parents involved in this study were upper-middle class, two-parent nuclear families living in Istanbul with no history of abuse. All of the mothers in the study were reported to be depressed and reported that their children watched television for an average of seven hours per day. In a three-month parenting program, parents were trained in strategies for managing behavioral problems in an age appropriate manner. In addition, this intervention helped parents to engage in self-care, including coping with guilt, limiting the amount of television their children watched, and initiating language training. A semi-structured interview and observations of the parent- child relationship was used to determine the current attachment relationship and subsequent improvements. Following the three month parenting program, a significant increase in behaviors associated with attachment was noted, including an improvement in eye-contact, social interest, and reciprocity of affection between parent and child. This study is especially noteworthy as is challenges the assumptions frequently held regarding the type of family that is at risk for attachment difficulty.

Psychoeducational interventions have proven effective as a means for precipitating attachment relationships between parents and their children. Psychotherapy offers another option for the treatment of attachment difficulties with a change in attachment status the outcome goal of such interventions (Eagle, 1994).

Psychotherapeutic Intervention

The research literature reports much ambiguity regarding the effectiveness of the various attachment therapies. O'Connor and Zeanah (2003) indicated the following,

"Despite more than 20 years since the establishment of disorders of attachment, there is still no consensual definition or assessment strategy, nor are there established guidelines for treatment or management" (p. 241). Furthermore, some attachment interventions, such as Attachment Therapy, are considered controversial and even dangerous (Mercer, 2003). Interventions to address attachment difficulties in children may differ depending on the age of the child, whether or not the child is institutionalized, in a foster home, in a foster adopt home, or returning to their family of origin. Effective intervention is further complicated by confusion regarding the connection between attachment security and other non-attachment co-morbid disorders (Hardy, 2007). Currently, treatment for attachment related issues and resulting behaviors is focused in the following areas: 1) enhancing current attachment relationships; 2) creating new attachment relationships; and 3) reducing problematic symptoms and behaviors (Hardy, 2007).

Hanson and Spratt (2000) identified attachment strategies that were helpful with creating attachment relationships with abused children. Cognitive Behavioral Therapy was identified as a strategy for managing symptoms associated with mood along with behavioral modification to address problematic behavior. Social support coaching to improve social relationships and self-efficacy and self-esteem enhancement was also included in this approach to attachment intervention.

Berlin (2001) described a therapeutic milieu approach to treating children with attachment difficulties that had been institutionalized. In this approach, children were encouraged to develop an attachment relationship with a milieu staff member by staying in close proximity to the staff member for a two-week period of time. Through the relationship that developed between the child and the staff member, the child learned to

meet milieu expectations and to regulate their behavior. As a result, the child earned freedoms and was given responsibilities. Individual and family therapy interventions were concurrent with milieu treatment to maximize outcome.

Play Therapy enactment of attachment issues is a treatment modality for young children that is reported to help enhance current attachment relationships, assists in creating new attachment relationships, and helps to reduce problematic behaviors (Fairchild, 2006). Play Therapy offers a forum for the child to symbolically represent their inner world including social relationships (Landreth, 2002). The play therapist that utilizes this intervention assists the child by focusing on attachment related themes that emerge in the course of play therapy (Fairchild, 2006). The Attachment Story Completion Task, the MacArthur Story Stem Battery, and the Manchester Child Attachment Story Task are the three primary play based narrative approaches and include story-telling tasks whereby the children use therapeutic toys to address issues related to attachment (Fairchild, 2006). Helping the child develop a healthy attachment relationship with the play therapist is also viewed as a part of the psychotherapeutic approach to treating children with attachment issues (Haugaard & Hazan, 2004).

According to Klassen (2006) and Slade (1999) no comprehensive approach to attachment intervention exists. Rather, attachment intervention strategies are often idiosyncratic, undeveloped, controversial, and leave the efficacy of the intervention in question (Slade, 1999). According to Slade, "an understanding of the nature and dynamics of attachment informs rather than defines intervention and clinical thinking" (p.577). When traditional attachment interventions do not appear helpful, parents and

caregivers may seek assistance from fringe therapies, which are considered controversial, and even dangerous (Mercer, Sarner, & Rosa, 2003).

"Fringe therapy" is defined as an intervention that is presented outside of the boundaries of psychology and medicine (Mercer, Sarner, & Rosa, 2003). This type of treatment is typically not covered by insurance, not used in public hospitals or clinics, is not taught by accredited university programs and is rejected by most credentialed mental health professionals and medical practitioners. In addition, fringe therapies could be considered invalid treatment as they are not substantiated by empirical evidence but emerge in the form of anecdotal experiences of the therapist (Boris, 2005).

Attachment Therapy is a "fringe therapy" intervention that has become increasingly popular. The following principles are the foundation of attachment therapy: 1) the child suffers from the inability to connect with his or her caregivers; 2) the child will be able to recapture emotional connections with the caregiver by regressing to an earlier stage of development which will lead to a positive outcome; 3) the child must release his or her anger and rage for emotional release and attachment to occur; and 4) overt demonstrations of affection and obedience are evidence of attachment (Mercer, Sarner, & Rosa, 2003; Chaffin et al., 2004). Attachment Therapy utilizes holding techniques and rebirthing experiences to facilitate attachment (Zilberstein, 2006). Reenactment of birthing process includes the child being wrapped tightly in a blanket to mimic the birthing experience while the adult presses against the child in an attempt to simulate contractions that occur in labor (Mercer, Sarner, & Rosa, 2003). The child is tasked with attempting to wiggle their way out of the blanket through a small hole in the

top and to emerge from the rebirthing experience as an emotionally attached child that is committed to a relationship with his or her caregiver (Mercer, Sarner, & Rosa, 2003).

Parenting techniques are also included in the Attachment Therapy intervention (Chaffin et al., 2004.). Parents are taught such behaviors as withholding food, demanding that the child engage in labor intensive work, shouting at the child to get their compliance or attention, threatening the child with abandonment, and forcing the child to maintain physical postures (such as holding the arms over the head) for long periods of time with the aim of breaking down the child's defenses. When the child complies with the parental request, comfort and support is provided (Zilberstein, 2006). In addition, education is treated as a privilege and not a right and the child is expected to behave in order to attend school, consequently, the child is in danger of becoming educationally disadvantaged (Mercer, Sarner, & Rosa, 2003).

To date, Attachment Therapy can be credited with the death of at least four children (Zilberstein, 2006). Candace Newmaker, a 10-year- old girl, died in 2000 in Colorado during the course of an Attachment Therapy intervention when she suffocated while tightly wrapped in a sheet (Chaffin et al., 2004). Krystal Tibbets, a four-year-old child, died in Utah in 1996 during the course of Attachment Therapy treatment administered by her father, as did 2-year-old David Polreis, an adopted child from Russia who was being treated by Attachment Therapy practitioners (Mercer, Sarner, & Rosa, 2003). Cassandra Killpack died in 2002 in Utah under circumstances related to Attachment Therapy as in a paradoxical intervention, she was forced to drink large quantities of water because she had gotten a drink of water without asking for permission (Mercer, Sarner, & Rosa, 2003).

Many practitioners within professional and research communities view Fringe therapies, such as Attachment Therapy, as both physically and psychologically risky to the child who is exposed to such treatment and do not advocate the use of such interventions (Chaffin et al., 2004). In further support of this stance is the limited empirical evidence to support the use of such controversial techniques (Chaffin et al., 2004; Mercer, Sarner, & Rosa, 2003).

Attachment research focuses on the relationship of specific behaviors the child engages in with the primary caregiver (Nilsen, 2003). Typically, foster or adoptive parents and the child welfare system view attachment as the child's current behavior, regardless of the relationship context in which these behaviors occur. As a result, any behavior or relationship the child exhibits may be viewed as an attachment problem (Nilsen, 2003). When foster and adoptive parents are taught about attachment through the child welfare system utilizing this behavioral theme rather than empirical literature, the foster parent seeks treatment for the behavioral issues and true attachment disorders remain untreated (Nilsen, 2003). A lack of validated instruments and empirically founded treatments for children with attachment problems further exacerbates the problem of providing effective treatment interventions (Klassen, 2000). Consequently, those behaviors that have a known treatment model come into focus (Nilsen, 2003).

Conceptualizing the factors and processes that lead to difficulties in treating attachment issues could be helpful to foster children. According to Pearce and Pezzot-Pearce (2002), the factors from Attachment Theory that interact together to form developmental difficulties are identified as Internal Working Models (IWM) and Interpersonal Schemata (IS). The IWM refers to mental representations the child begins

to develop based on interactions with their primary care giver (Bowlby, 1969). IS refers to expectations the child experiences in response to the way her or she is responded to by others, can refer to a wide range of relational patterns, and is not tied solely to care giving and receiving (Pearce & Pezzot-Pearce, 2002). Foster children are at risk for developing negative IWM and IS that can carry over into the foster relationship. Foster children who have developed negative IWM's and IS's may generalize these negative expectations of others and self to new situations resulting in maladaptive behavior (McAuley, 1996). When foster parents have difficulty with these maladaptive behaviors, their relationships with the child may deteriorate, exacerbating negative expectations, leading to further dysfunction and even a disruption in the foster placement (McAuley, 1996).

To maximize the effectiveness of any treatment that seeks to address attachment issues, a family practice model of intervention should be incorporated to include the foster parents in treatment, as the efficacy of treatment is increased when the therapist works in conjunction with other people who care for the child (Pearce and Pezzot-Pearce, 2002). In addition, the attachment intervention should target the quality of the existing relationship between a foster parent and foster child by focusing on improving this relationship (Liberman, 2003). Improving the foster parent's perception of the child as well as helping them to develop appropriate parenting strategies will improve the emotional health of the foster child (Liberman, 2002).

Summary

Because the research literature reports ambiguity regarding the efficacy of the various attachment therapies, it is important to continue to consider viable options. Filial Therapy may be one such option. Filial Therapy addresses the etiological and treatment

issues referred to in the attachment literature such as improving empathy, addressing the child's problematic behavior, changing the parent's behavior and providing a forum for support and the development of interpersonal skills (Bratton & Landreth, 2006). In addition, Filial Therapy is a treatment modality that has been proven effective under various conditions and with a variety of populations (Bratton et al., 2005). As previously mentioned, no empirical literature was found that attempts to determine the efficacy of this intervention in regards to attachment, which adds credibility to the need for research in this area. It is logical to believe that this intervention is worth considering as a therapeutic intervention to diminish behaviors associated with attachment difficulties in foster children with disrupted attachments, which is the focus of this research. Chapter 3 will provide an overview of the research methods used throughout this study.

CHAPTER THREE

Methods

Foster children are increasingly being diagnosed and treated for behaviors that are associated with attachment disruption and related difficulties (Eagle, 1994). Slade (1999) reported that few comprehensive approaches to attachment interventions exist. This study sought to determine if Child Parent Relationship Therapy was an effective approach to attachment intervention and investigated the effects of CPRT on the observed behaviors of foster children with attachment difficulties. Chapter three provides an overview of the research methods utilized in this study and includes variables, research questions, hypotheses, participants, instrumentation and procedures.

The treatment in this investigation was the 5-week CPRT program. The dependent variable in this study is the children's behavior associated with attachment difficulty as defined by the Randolph Attachment Disorder Questionnaire (RADQ). The independent variables include the following: (1) the age of the foster child, (2) the gender of the foster child, and (3) the number of foster home placements that the child has experienced. This study sought to provide answers to the following research question: How will participation in CPRT affect the observed behaviors exhibited by foster children with attachment problems?

Instrumentation

Behaviors associated with attachment difficulty in children ages two to eighteen can be measured by using the Randolph Attachment Disorder Questionnaire instrument (Randolph, 2000). The RADQ is a 30-item inventory that examines behaviors associated with attachment difficulty assessing five factors: 1) asocial behaviors; 2) social

behaviors; 3) delinquent behaviors; 4) antisocial behaviors; and 5) controlling behaviors. A five-point rating scale has been used to represent the participant's perception of the child's behaviors and or traits. A score of one would indicate "rarely", less than 10% of the time; a score of two would indicate "occasionally", about 25% of the time; a score of three signify "sometimes", about 50% if the time; a score of four represents "often", 75% of the time; and a score of five represents "usually", 90% of the time. The instrument is scored by adding a cumulative score minus 30 points to establish the level of attachment disorder. A score of 65–75 indicates a mild form of attachment difficulty associated with an avoidant or anxious sub-type of attachment difficulty; a score of 76–89 indicates a moderate degree of attachment difficulty; and a score of 90 and above indicates severe attachment difficulty and would be associated with an Ambivalent sub-type of attachment difficulty.

The Attachment Symptoms Checklist (ASCL) that was used for over 20 years in a residential program known as the Attachment Center in Evergreen, Colorado was the predecessor to the RADQ (Fairchild, 2000). This check-list included commonly observed behaviors that children with attachment problems typically exhibit. The scale was developed through a pilot study (*N=80*) that utilized a 40-item attachment system checklist with children who had no clinical diagnosis or with Attachment Disorder, or Conduct Disorder (Fairchild, 2000). The ASCL was revised into a 30 item inventory that became the Attachment Disorder Questionnaire Revised (ADQ-R) (Randolph, 2000). This inventory was then studied with a different group of children who had a history of maltreatment, a diagnosis of Attachment Disorder, and neither a history of maltreatment, nor Attachment Disorder or who were never involvement in therapeutic services

(Fairchild, 2000). The final revision of the ADQ-R resulted in the development of the RADQ. The RADQ was the most appropriate published assessment tool for the targeted population of this study.

The RADQ is a published instrument (Fairchild, 2006; Randolph, 2000) with reliability shown by test–retest correlation coefficients of *.82* for the Attachment Disorder group, and *.85* for the non-clinical group were reported regarding reliability. Cronbach's alpha for internal consistency measures for the Attachment Disorder group were *.84; .81* was indicated for the maltreated group, establishing internal consistency for the RADQ (Randolph, 2000). Construct validity was determined by correlating scores on the RADQ with sub-scales of three other published instruments. The Personality Inventory for Children (PIC), indicated two subscales out of six were statistically significant including delinquency ($r = .48, p<.001$). The Child Behavior Checklist (CBCL) yielded two out of eight statistically significant subscales including delinquent behavior, $r = .36, p<.01$, and the Millon Adolescent Personality Inventory (MAPI) indicated that one subscale out of 12 was statistically significant, personal esteem, $r = .37, p<.01$ (Randolph, 1997). The correlation between the RADQ and these three standardized instruments was determined through a pre- and post-treatment of clients at the Evergreen Attachment Center (Fairchild, 2006). A replication study by Myeroff, Mertlich & Gross (1999) corroborated the effectiveness of this assessment instrument.

For the purpose of this research study, the RADQ instrument measure was in no way used to diagnose an attachment disorder; rather, it was used to assess the extent to which CPRT or participation in a support group precipitated changes in problematic attachment behaviors. According to Fairchild (2000) and Randolph (2000), this

instrument should never be used solely for the sake of attachment diagnosis; rather, the use of other psychological testing measures and an assessment history should be included in any diagnosis process. Instead, the RADQ was utilized to attempt to answer the following questions.

Research Questions

Research Question 1: Will the quasi-experimental group score significantly lower (*p< .05)* on the total RADQ score of behaviors associated with attachment difficulty when compared to the total RADQ score of the control group subsequent to the CPRT intervention?

Hypothesis 1: There will be no significant difference in the quasi-experimental group's change in total RADQ score of behaviors associated with attachment difficulty when compared to the change in the total RADQ scores of the control group.

Research Question 2: Will the quasi-experimental group score significantly lower (p< .05) on the subscales of the RADQ score of behaviors associated with attachment difficulty when compared to the subscales of the RADQ scores of the control group subsequent to the CPRT intervention?

Hypothesis 2: There will be no significant difference on the quasi-experimental group's subscale scores of behaviors associated with attachment difficulty when compared to the subscale scores of the control group.

Research Question 3: Will the age of the foster child influence the behaviors associated with attachment difficulties?

Hypothesis 3: The mean score of behaviors on the RADQ associated with attachment difficulties exhibited by older children will not differ from the mean score of behaviors on the RADQ exhibited by younger children.

Research Question 4: Will the gender of the foster child influence the behaviors associated with attachment difficulties?

Hypothesis 4: The mean score of behaviors on the RADQ associated with attachment difficulties exhibited by male foster children will not differ from the mean post-test score of behaviors on the RADQ exhibited by female foster children.

Research Question 5: Will the number of foster home placements experienced by the foster child influence behaviors on the RADQ associated with attachment difficulties?

Hypothesis 5: The mean RADQ scores of foster children who have experienced multiple foster placements (more than one) will be equal to the mean RADQ scores of children who have experienced one placement.

Participants

Foster children who have been placed in care may have experienced abuse, neglect, deprivation, parental substance abuse, or abandonment, all of which may result in attachment disruption. Consequently, it is believed that children in foster placement will exhibit behaviors associated with attachment difficulties, and foster parents must manage the challenges presented by these behaviors. Foster parents and foster children from the East Tennessee area were recruited to participate in this study. The primary participants in this study were foster parents although the foster children were indirect participants. Because foster children are wards of the state, the investigator sought

permission from the State of Tennessee for permission for foster children to be indirect participants in this research study (Appendix A). The investigator recruited participants through contacts made with the Department of Children Services (DCS) Foster Services Program, and the Knox County Foster Parent Association. Caseworkers from Knox County DCS provided information about the training and support groups to all foster parents within their jurisdiction (Appendix B & Appendix C). The Knox County Foster Parent Association announced the training and support groups in their monthly meetings.

Foster parents who were interested in participating in this research study were required to meet the following criteria: 1) the foster parent was able to read and write on the 6th grade level as evidenced by his or her ability to complete the initial assessment; 2) the foster parent was willing to commit to the 5-Session Filial Therapy format or the 5-Session Foster Parent Support Group; 3) the foster parent was willing to commit to two thirty minute play sessions each week with his or her foster child during the training session (quasi-experimental group only); 4) the foster child had consent from the state to participate in the study; 5) the foster parent gave their informed consent to participate in the study; 6) the foster child was between the ages of two and nine years of age; 7) the foster child was able to engage in representational play (quasi-experimental group only); 8) the intake process indicated that the foster parent was an appropriate candidate for CPRT (as evidenced by minimal emotional distress; able to focus on the needs of the foster child); and 9) the intake process indicated that the foster child was an appropriate candidates for CPRT (foster parent indicated that he or she was able to cope with the emotional difficulties and behaviors exhibited by the foster child).

There were clinical factors that precluded the foster parent and foster child from participation in the CPRT intervention. These factors included foster parents who were experiencing emotional distress to the point that they were unable to focus on the needs of the foster child and emotional difficulties or behaviors exhibited by the foster child that were too extensive for the foster parent's capabilities as indicated by the foster parent's self-report (Landreth & Bratton, 2006). None of the participants who sought participation in this research study were precluded based on the above mentioned criteria.

Procedures

This investigation was conducted by a Licensed Professional Counselor trained and experienced in play therapy, Filial Therapy, and CPRT techniques who has over fifteen years of experience working with foster children and foster families. The investigator was supervised by University Faculty for the duration of this study. The investigator supervised the completion of the RADQ by foster parents in both the quasi-experimental and the control groups. In addition, the investigator led the quasi–experimental group involved in this study using a modified Landreth Child-Parent-Relationship Training Model (10-Session Filial Therapy Model) and the control group which consisted of a support group for foster parents.

During the course of this research, three quasi-experimental groups and two support groups were conducted in order to acquire the 30 participants needed for the study (*N=30*). The investigator experienced significant difficulty in recruiting participants, perhaps due to the time investment necessary for participation. As a result, group assignment was made according to non-probability sampling, in particular, the purposive sampling method as two specific pre-defined groups were being sought for the

study. The quasi-experimental group was comprised of 11 foster mothers and four foster fathers who ranged in age from 32 to 60 years. Participants had varying degrees of experience as a foster parent ranging from six months to 28 years. Foster parents in the quasi-experimental group were 93% Caucasian and 7% African American. Sixty-six percent of the foster parents were married, 20% were single, and 14% were widowed.

Fifteen foster children were indirect subjects of the group as each foster parent was required to have a foster child within the two to nine year age range to be the focus of the RADQ assessment. Foster children in the quasi-experimental group ranged in age from two to nine years; nine were male and six were female.

The control group consisted of eight foster mothers who ranged in age from 32 to 70 years of age. All of the foster parents in the control group were female, 100% were Caucasian, and 100% were married. Fifteen foster children were indirect subjects of the group as each foster parent was required to have at least one foster child between the ages of two and nine to be the focus of the RADQ assessment. Three foster mothers had one foster child involved in the study and five foster mothers had more than one foster child who participated in the research. The foster children ranged in age from two to eight years of age; six were male and nine were female. Subsequent to the completion of the control group, foster parents were given the opportunity to participate in CPRT at a time that was scheduled after the conclusion of the research data collection.

Two locations were utilized for this research study. A clubhouse of a local condominium was the site used for two CPRT groups and two support groups and a non-denominational church was the location used for one CPRT group. The investigator was able to procure the facilities at no charge.

Foster parents were able to participate in either group at no charge. Additional benefits were derived when DCS allowed the CPRT group members to receive 15 hours of yearly mandatory training for their participation in CPRT. Because DCS requires foster parents to participate in a total of 15 training hours per year, participation in the quasi-experimental group accounted for the foster parent's total yearly training hours. Support group members where allowed to receive eight hours toward their yearly mandatory training for participation in the Support group. Members in the CPRT group received an additional monetary benefit in the form of a $25 stipend that they received after the third session.

Quasi-Experimental Group

The quasi-experimental group followed the Landreth 10-Session CPRT Filial Therapy Model and utilized didactic instruction, role-play, demonstration, homework assignments, and play sessions between parent and child to facilitate a change in relationships and a change in the child's presenting behaviors. This model was adapted from a 10-Session, one and a half hour per week training program to a 5- Session, three hours per week training program with documented success (Harris & Landreth, 1997). Because many foster parents might find it difficult to commit to a 10 week training program, this study was modified to a Five-session format to facilitate participation in the intervention and to add to the research literature regarding the effectiveness of the Five-session design.

The investigator met with each foster parent participant to explain the purpose of the research, the requirements of CPRT, information pertaining to confidentiality and its limits, as well as to answer any questions the foster parent may have about the training or

research. An initial assessment was also conducted by the investigator to ensure that the foster parent and the foster child were candidates for CPRT (Appendix D). Screening data from the parent and child's background was compiled by the investigator for appropriateness for the research study based on data obtained from the foster parent during intake. At the time of intake, the investigator explained the basics of the CPRT training format and addressed any questions or concerns the foster parent had regarding the process. Foster parents who agreed to participate in the study completed an informed consent form (Appendix I).

The investigator presented the CPRT training program to the foster parents using a psychoeducational model outlined in the CPRT therapist's notebook (Appendix F) to ensure that critical teaching and training elements were incorporated (Landreth & Bratton, 2006). These training elements included the following: 1) structuring for success; 2) modeling acceptance; 3) reflective listening and focused attention; 4) fallibility of the therapist; 5) encouraging parent strengths; 6) utilizing specific instruction; 7) providing concrete examples; 8) imparting expert knowledge; 9) encouraging role play and practice skills; 10) using analogies to increase parent awareness; 11) touching the inner world of the parent; 12) making suggestions for improvement; 13) identifying what is learned from special playtimes; 14) identifying shifts or changes in behavior; 15) facilitating insight; and 16) clarifying.

The foster parents in the quasi-experimental group were provided a *Handbook for Parents* (Landreth & Bratton, 2006) that served as a detailed guideline for the process (Appendix G). The foster parents participated in five, three-hour training sessions whereby they were instructed in the basic skills of CPRT. The foster parent CPRT groups

met once a week for a total of five weeks. The CPRT sessions followed the methodology outlined in the Landreth and Bratton (2006) CPRT model.

Training session one.

In the 1st session of CPRT, foster parents introduced themselves, their reasons for participating in the group, described their families, and identified their foster child of focus. Confidentiality and methods for maintaining confidentiality in the context of the research were discussed along with the limits to confidentiality and the investigator's role as a mandatory reporter of suspected child abuse, abuse to the elderly, suicidal ideation, and homicidal ideation. The investigator gave participants an overview of CPRT and discussed the trainings objectives, goals, and essential concepts as identified by Landreth & Bratton (2006). The foster parents were introduced to reflective listening, the "30-second burst of attention" technique, and basic play session skills.

The homework assignments for the first session were identified by the investigator and included practicing reflective responding and the "30-second burst of attention". Foster parent were asked to take notes on their successes or challenges with these new skills. In addition, foster parents were to note a characteristic of their foster child that they had not noticed before and to bring a favorite picture of their foster child. Foster parents were asked to begin collecting toys for play sessions and to select a time and place for them to be held.

Training session two.

Training session two began with a review of the homework. Foster parents elaborated on successes or challenges experienced when attempting reflective listening and the "30-second burst of attention" with their foster child. The investigator reviewed

the play essentials and discussed and demonstrated ways to set up the play space. In addition, the investigator demonstrated each toy on the play list and its role as a therapeutic agent in special play time. The investigator further demonstrated the skills to be used when conducting a play session. Participants viewed a DVD (Landreth, 2002) that detailed special play time and served to reinforce previously discussed concepts. Parents were given the opportunity to role-play, taking turns being the parent and the child. Parents were further instructed in appropriate ways to explain special play time to their foster child.

The investigator introduced therapeutic limit setting using the ACT format; "A", acknowledge the feeling; "C", communicate the limit; and "T", target an acceptable alternative to the behavior. The investigator demonstrated the technique and the foster parents practiced ACT in role-play. Foster parents were challenged to practice this new skill with their foster child both outside and within special play time if needed.

The homework assignments for training session- two were discussed and included completing the selection of toys for special play time and implementing a schedule for playtime that would be held at the same day, time and place each week for consistency. Foster parents were reminded to conduct two, thirty-minute play sessions with their foster child during the coming week. Participants were reminded to read over the handouts in the parent handbook pertaining to special play time and to read the play session guidelines prior to the first session. Foster parents were also asked to record notes in the *Parent Play Session Notes* section of the *Parent Handbook* (Landreth & Bratton, 2006) subsequent to play sessions. Parent notes detailed the following: 1) significant happenings; 2) play themes; 3) feelings expressed by the foster child; 4) skill the foster

parent felt most comfortable with; 5) skill that was most challenging to the foster parent; 5) feelings the foster parent experienced during the session,;6) what the foster parent learned about themselves; 7) what the foster parent learned about their foster child; and 8) skills the foster parent would like to focus. The foster parents were further asked to practice ACT therapeutic limit setting in the next week.

Training session three.

In session three, the foster parents reported on the special play time times that were held the previous week. The participants discussed and processed the concerns and difficulties that they had experienced when implementing special play time. The investigator reviewed the homework assignments with the group members including the play session guidelines, active listening, and therapeutic limit setting. The investigator introduced and demonstrated the topics of sandwich hugs and kisses, and choice giving. The group then divided into groups of two to role-play these skills.

Homework assignments for session three were introduced by the investigator and included the continuation of two play sessions with the foster child during the coming week to be held on a consistent day at a consistent time and place. Foster parents were asked to continue to read over the play session guidelines prior to play sessions and to continue to complete *Parent Play Session Notes* (Landreth & Bratton, 2006). If the foster parent had to use therapeutic limit setting in the play session, the parent was asked to detail its use and to describe how the technique worked. Foster parents were asked to practice sandwich hugs and kisses and choice giving and to read *Choice Giving 101 and Advanced Choice Giving* (Landreth & Bratton, 2006) and *Common Problems in Play*

Sessions (Landreth & Bratton, 2006). Parents were asked to mark the areas in the handouts that were problematic to them.

Training session four.

Training session four began with a review of the homework and parents reported on play sessions. The group continued to discuss, demonstrate, and role-play therapeutic limit setting and choice giving. The investigator introduced, discussed, and demonstrated *Building Your Child's Self-esteem* and *Encouragement versus Praise* (Landreth & Bratton, 2006). The group divided into groups of two to role-play and practice these new skills.

The homework assignments for session four included the continuation of two play sessions, recording sessions in the *Parent Play Session Notes* (Landreth & Bratton, 2006). The foster parents were asked to focus on esteem building responses and encouraging responses during special play time. Foster parents were asked to read *Esteem Giving Responses, Encouragement versus Praise,* and *Limit Setting Choice* (Landreth & Bratton, 2006) before their next play session. In addition, participants were asked to write at least one issue that they are struggling with outside of play.

Training session five.

In session five, parents continued to report on play sessions and the investigator reviewed the homework assignments with the foster parents. Because the fifth session was the final meeting, the therapist recapped all of the skills learned in training including the "30-second burst of attention", active listening, therapeutic limit setting, self-esteem building responses, and choice giving. The investigator introduced *Structured Doll Play* (Landreth & Bratton, 2006) as a way of helping foster children prepare for stressful

events or events that might cause anxiety. Through structured doll or stuffed animal play, the foster parents could help the foster child understand what would take place and would include the foster children in the process.

The foster parents discussed changes that had occurred as a result of their participation in CPRT. These changes included changes in the foster parents, and changes in the foster child. In addition, the foster parents discussed their overall experience of the training. The investigator recommended that foster parents continue special play time with their foster child for at least six weeks to continue benefits gained through play.

Control Group

An experienced Licensed Professional Counselor, who was also the investigator, facilitated the control groups that met once a week for five weeks, for one and a half hours each session. The control groups were presented in a support group format and were specifically intended to meet the needs of the foster parents. The two support groups that formed in conjunction with this study were allowed to formulate group goals, and the investigator facilitated their interaction.

The first group indicated that they wanted to advocate for system change; i.e., improvement in the delivery of services to foster parents and foster children on the part of the Department of Children's Services (DCS). Such changes would be beneficial to foster children and would ensure that foster parents had the support they needed to "do such an important job". The group identified the following as their goals: 1) identify ways to improve communication between DCS and foster parents; 2) identify ways to improve foster care placement procedures; 3) understand the legal and advocacy issues within their role as foster parents; 4) advocate for better training and development of foster

parents; 5) understand better ways to work with birth families; and 6) identify resources available to foster children and birth families. These goals were the focus of the group's agenda, and members did not deviate from these set objectives.

The second group indicated a desire to avoid discussing systemic issues and especially DCS. Instead, this group expressed an interest in discussing therapeutic issues experienced by their foster children. In particular, the group wished to discuss disorders such as Attention Deficit Hyperactivity Disorder, Bipolar Disorder, Sensory Integration Disorder, and Reactive Attachment Disorder. They further indicated a desire to discuss effective ways to handle behavioral problems and other issues, such as medication, and medication management associated with these diagnoses. These goals remained the focus of the group's discussion throughout the five week session.

Overall, the support groups provided the foster parents with an opportunity to discuss and process the challenges of being a foster parent with other foster parents who were experiencing similar challenges and successes. A variety of resources that were available to foster parents and foster children was discussed including medical professionals, educational resources, and advocacy issues related to foster children and training opportunities, financial resources, dealing with the system, and coping strategies for foster parents. In addition, the support group provided a forum for foster parents to address and promote quality foster care.

Data Analysis

Following the completion of the 5-Session CPRT interventions and the 5-Week Foster Parent Support Groups, the foster parents completed a post-test of the Randolph Attachment Disorder Questionnaire. The pre-test and post-test scores on the RADQ of

the quasi-experimental group were compared to the pre-test and post-test scores on the RADQ of the control group using a Repeated Measures ANOVA for research question number one: Will the quasi-experimental group score significantly lower ($p < .05$) on the total RADQ score of behaviors associated with attachment difficulty when compared to the total RADQ score of the control group subsequent to the CPRT intervention?

To compare the experimental and control group scores on the RADQ subscales, a MANOVA was applied for research question number two: Will the quasi-experimental group score significantly lower ($p < .05$) on the subscales of the RADQ of behaviors associated with attachment difficulty when compared to the subscales of the RADQ of the control group subsequent to the CPRT intervention? Because the MANOVA was significant, individual ANOVA's were conducted to determine which subscales differed.

A one-way ANOVA was applied to determine the answer to research question number three: Will the age of the foster child influence the behaviors associated with attachment difficulties? A MANOVA was also conducted to determine if there were differences in the RADQ subscales according to age group.

An Independent sample T-test was conducted to determine the outcome of research question number four: Will the gender of the foster child influence the behaviors associated with attachment difficulties; and research question number five: Will the number of foster home placements experienced by the foster child influence behaviors on the RADQ associated with attachment difficulties?

Summary

Attachment theory provides a theoretical framework that influenced the design of this investigation. The pre-test, post-test, quasi-experimental, and control group design

was chosen as the best format to determine whether or not CPRT will affect the observed behaviors exhibited by foster children with attachment problems, if the age of the foster child, the gender of the foster children, or the number of foster placements will influence the observed behaviors exhibited by foster children with attachment difficulties, and if CPRT is an affective treatment for foster children with attachment issues. The number of participants selected to participate in this investigation was determined in order to facilitate the possibility of generalization of any research findings.

The Randolph Attachment Disorder Questionnaire was selected for this study as it is a published attachment assessment instrument that measures the attachment behaviors of children between the ages of two and eighteen years. This age range fit the two to nine year age range that was the focus of this intervention, which was the primary reason for its usage. The RADQ is a published instrument with reliability and criterion-referenced, construct, content, and predictive validity (Randolph, 1997; Fairchild, 2006), and is not too complicated for use by foster parents who will be completing the assessment.

The CPRT intervention was conducted by a Licensed Professional Counselor who has over fifteen years of experience working with foster children and foster parents and is trained in both play therapy and CPRT techniques using a psychoeducational model of instruction. CPRT was held over a period of five weeks with groups meeting one time per week, three hours per session, for the five week period. The control group was held over a period of five week period of time with group members meeting once a week for one and a half hours per session. Subsequent to the CPRT intervention, pre-test scores of the RADQ were compared with post-test scores using an Individual T-test, a 2-way Repeated Measures ANOVA, a MANOVA and individual ANOVA's on the subscales of the

RADQ to determine the efficacy of this intervention for decreasing behaviors associated with attachment difficulties. Chapter Four presents the results of this research and the analysis of data.

CHAPTER FOUR

Results

This chapter presents the results of the data analysis for each hypothesis tested in the study. The results of this study are presented in the order the hypotheses were tested. A level of significance of .05 was established as the criteria for retaining or rejecting the hypotheses.

Hypothesis 1: There will be no significant difference in the quasi-experimental group's change in total RADQ score of behaviors associated with attachment difficulty when compared to the change in the total RADQ scores of the control group.

A Repeated-Measures ANOVA was conducted to determine if the scores of the quasi-experimental group were significantly different from the scores of the control group in regard to the total RADQ score of behaviors associated with attachment difficulty. No significant group interaction was found ($p = .492$) indicating that improvement in behaviors associated with attachment difficulty did not differ between the two groups $[F(1,28) = .485, p = .492]$. Thus the null hypothesis was retained for Hypothesis 1. However, the results also indicate that time is significant, therefore regardless of the group, an improvement in behaviors associated with attachment difficulty did occur over time $[F(1,28) = 4.464, p = .044]$. Table 1 represents the pre and post-test scores of the quasi-experimental group and the control group demonstrating that time is significant but that there is no significant difference between the experimental and control groups' total RADQ scores. The pre-test means of both groups was *68.43* and post-test means of both groups was *62.27.* Table 2 represents the total aggregate RADQ scores of both the quasi-experimental and the control group.

Table 1.

Results for the Repeated Measures ANOVA Pre and Post-Test Randolph Attachment Disorder Questionnaire Scores of the Quasi-Experimental and Control Group

	F	df	P
Time	4.464	1,28	.044
Group	3.905	1,28	.058
Time*Group	.485	1,28	.492

Table 2.

Total Aggregate Randolph Attachment Disorder Questionnaire Scores of the Experimental and Control Group

		Mean	Standard Error
Quasi-experimental Group	1	60.733	6.692
	2	52.533	6.448
Control Group	1	76.133	6.692
	2	72.000	6.448

Note. 1 = Pre-Test. 2 = Post-Test

Hypothesis 2: There will be no significant difference on the quasi-experimental group's subscale scores of behaviors associated with attachment difficulty when compared to the subscale scores of the control group.

Repeated-Measures ANOVAs were conducted to determine if the subscales of the quasi-experimental group differed in the areas of asocial, social, delinquent, anti-social, or controlling behaviors when compared to the subscales of the subscales of the control

group. The results of the Repeated-Measures ANOVAs are in Table 3. The only significance was an overall group difference for the social subscale (*p = .023*) indicating the control group had more social issues both pre-test and post-test (*x = 2.606*) than the quasi-experimental group (*x = 1.894*).

Table 3.

Results for the Repeated-Measures ANOVA for Randolph Attachment Disorder Questionnaire Subscales

	F	df	p
Asocial			
t	1.291	1,28	.265
g	2.264	1,28	.144
t*g	.036	1,28	.85
Social			
t	2.171	1,28	.152
g	5.823	1,28	.023
t*g	.462	1,28	.502
Delinquent			
t	2.904	1,28	.099
g	2.168	1,28	.152
t*g	.150	1,28	.701
Anti-social			
t	1.425	1,28	.243
g	3.473	1,28	.073
tg	.532	1,28	.472
Controlling Behaviors			
t	3.378	1,28	.077
g	1.928	1,28	.176
tg	.028	1,28	.869

Note. t = time. g = group. tg = time x group.

Hypothesis 3: The mean score of behaviors on the RADQ associated with attachment difficulties exhibited by older children will not differ from the mean score of behaviors on the RADQ exhibited by younger children.

A One-Way ANOVA was performed to determine if the age of the child influenced the behaviors associated with attachment difficulty as measured by the total RADQ pre-test score. The results of the One-Way ANOVA are in table 4. There was no significant difference between the experimental and control groups' mean scores on the basis of age *[F (2,27) = 1.454, p = .251]*. Therefore the null hypothesis was retained for Hypothesis 3.

Table 4.

Results of the One-Way ANOVA for the Pre-Randolph Attachment Disorder Questionnaire Total According to Age

	df	F	P
Between Groups	2	1.454	.251
Within Groups	27		
Total	29		

A MANOVA was conducted to determine if there were differences in the RADQ subscales according to age group in regard to asocial, social, delinquent, anti-social or controlling behaviors. The results of the MANOVA indicated at least one subscale differed according to age [F (10,46) = 2.099, p = .044], which indicated a significant finding. Therefore the null hypothesis was rejected for Hypothesis 3. Because of this significance, individual ANOVAs were run to determine which subscales differed. No significance was found according to subscales of the RADQ in regard to age group.

Hypothesis 4: The mean score of behaviors on the RADQ associated with attachment difficulties exhibited by male foster children will not differ from the mean post-test score of behaviors on the RADQ exhibited by female foster children.

An Independent-Sample T-Test was conducted to determine if the total pre-test RADQ scores of the quasi-experimental group differed from the total pre-test RADQ scores of the control according to gender. The quasi-experimental group included nine boys and six girls and the control group consisted of nine girls and six boys. The results of the Independent Sample T-Test are indicated in Table 5. There were no significant findings in relation to the total RADQ scores in regard to gender *(t (28) = -.074, p = .941)*; therefore the null hypothesis was retained for Hypothesis 4. A MANOVA was conducted to establish whether or not there were subscale differences in regard to asocial, social, delinquent, anti-social or controlling behaviors in relation to the gender of the child. There were no significant subscale differences in regard to gender *[F (5,24) = 1.118, p = .378]*.

Table 5.

Results of the Independent Samples T- Test According to Gender

		Levene's Test for Equality of Variances		t-test for Equality of Means		
		F	P value	t	df	P value
Pre-RADQ Total	Equal variances assumed	.011	.918	-.074	28	.941

Hypothesis 5: The mean RADQ scores of foster children who have experienced multiple foster placements (more than one) will be equal to the mean RADQ scores of children who have experienced one placement.

An Independent Sample T-Test was run to determine if the number of foster placements experienced by the foster child contributed to the total RADQ score of behaviors associated with attachment difficulty. The results of the Independent Sample T-Test are indicated in Table 6. There were no significant findings in regard to the post-test RADQ scores of the quasi-experimental group when compared to the post-test RADQ scores of the control group in relation to the number of foster placements experienced by the child *(t (.28) = -1.452, p = .158]*. Therefore, the null hypothesis was retained for Hypothesis 5. A MANOVA was conducted to establish whether or not there were subscale differences in regard to asocial, social, delinquent, anti-social or controlling behaviors in relation to the number of foster placements experienced by the child. There were no significant subscale differences in regard to the number of foster placements *[F (5,24) = .608, p = .694).*

Table 6.

Results of the Independent Samples T- Test According to Placements

		Levene's Test for Equality of Variances		t-test for Equality of Means		
		F	P value	t	df	P value
Pre-RADQ Total	Equal variances assumed	2.552	.121	-1.452	28	.158

Summary

Chapter four presented the results of the data analysis for each hypothesis tested in the study with a level of significance of *.05* established as the criteria for retaining or rejecting the hypotheses. Hypothesis 1 was retained as there were no significant differences in the quasi-experimental group's total post-test RADQ score of behaviors associated with attachment difficulty when compared to the total post-test RADQ scores of the control group. However, time was significant, therefore regardless of the group, an improvement in behaviors associated with attachment difficulty did occur over time.

Hypothesis two was rejected when a MANOVA indicated that the subscales of the post-test of the quasi-experimental group indicated an improvement in the areas of asocial, social, delinquent, anti-social or controlling behaviors when compared to the subscales of the post-test of the control group. There was a significant overall group difference in social behaviors with the control group experiencing more problematic social behaviors than the quasi-experimental group both pre- and post-test. Individual ANOVAs were run to determine which subscales differed with no statistically significant findings.

Hypothesis 3 was retained as there were no significant differences in total RADQ scores on the basis of the age of the child. A significant difference was found when a MANOVA was conducted on the subscales, however, the individual ANOVAs found no significance on the basis of age in regard to the subscales of the RADQ.

Hypothesis 4 was also retained as the post-test RADQ scores of the quasi-experimental group did not differ from the post-test RADQ scores of the control according to gender. In addition, the null hypothesis was also retained for Hypothesis 5 as there were no significant findings in regard to the post-test RADQ scores of the quasi-experimental group when compared to the post-test RADQ scores of the control group in relation to the number of foster placements experienced by the child. Chapter five discusses the findings of this research and introduces recommendations for future research.

CHAPTER FIVE

Discussion

The quantitative results of this study provided outcome data regarding the efficacy of CPRT in diminishing behaviors associated with attachment difficulty. In addition, this research provides information regarding the effectiveness of the Five-session format of CPRT training with foster parents and foster children and the efficacy of foster parents as therapeutic change agents.

Overall Changes in RADQ Behaviors

As indicated in Table 1, the scores of the quasi-experimental group were not significantly different from the scores of the control group in regard to the total RADQ score of behaviors associated with attachment difficulty. However, time was significant as both groups showed an improvement in behaviors associated with attachment difficulty over time. The findings of this study may have been influenced by the sample size that appeared to significantly limit these quantitative findings and contributed to results that were not statistically significant. It is important to point out that this research study compared CPRT to an alternative treatment group: a support group. Previous CPRT and Filial Therapy studies have compared the treatment group to a non-treatment group. As a result, evaluating CPRT's effectiveness at reducing problematic behaviors associated with attachment difficulties may generate different results if compared to a non-treatment group. Nevertheless, the fact that foster children benefited from indirect participation in the control group is significant as helping foster children diminish behaviors associated with attachment difficulties was the primary focus of the intervention. One cannot be disappointed that those in the control group also benefited.

The parenting style of foster parents may have further contributed to a lack of significance regarding overall changes in problematic behaviors. Two of the foster fathers in the quasi-experimental group had difficulty relinquishing their authoritarian parenting style. In order for CPRT to be successful, it is important that foster parents who tend to utilize an authoritarian parenting style surrender this mode of parenting in favor of an authoritative approach to parenting (Landreth & Bratton, 2006). Because these foster parents had difficulty relinquishing control of the play sessions with their foster child and had a tendency to lead the play, it is unclear if either the foster parent or foster child was able to benefit from CPRT training.

The Five-session format of the CPRT training, though convenient to foster parents, may have affected the outcome of this study as foster parents were exposed to a great deal of information in a short period of time, were required to spend three hours a week in training and approximately one hour per week with homework assignments, and were asked to conduct two therapeutic play sessions with their foster children (a total of six play sessions over a three-week time frame as play sessions did not begin until the 3rd week of the training). It is also possible that not enough time had elapsed for some of the participants to observe changes in the child's behaviors. It is important to note, however, that most of the parents did perceive changes in their foster child's behaviors as evidenced by self-report.

Foster parents involved in CPRT training did not always conduct two therapeutic play sessions with their foster child. In order for CPRT to be most effective, it was necessary for foster parents to conduct special play time with their foster child on a weekly basis two times a week for 30 minutes per play time. Because four foster parents

indicated that they did not initiate play sessions according to this schedule, there was a potential for outcome variables to be affected adversely.

Differences in Subscale Scores of Overall Changes in RADQ Behaviors

As indicated in Table 2, the only significance in the subscale scores of overall changes in RADQ behaviors was an overall group difference for the social subscale of the RADQ in the control group. This indicated that the foster children in the control group had more social issues in both the pre-test and the post-test than the quasi-experimental group. This finding may have resulted because it appeared that new foster parents were more attracted to the support group than the quasi-experimental group. Because new foster parents may be less skilled in dealing with problematic social behaviors, this may have contributed to the significance of this research finding.

RADQ Scores According to Age of the Child

Table 3 indicated that there was no significant difference between the quasi-experimental and control groups' mean scores on the RADQ on the basis of age. The use of two and three year olds in the study may have impacted the results as this age group will not have developed some of the problematic behaviors measured by RADQ, in particular, the delinquent and antisocial behaviors. Of the thirty participants, twelve foster children were in the two to three year old range, which may have further limited the statistically significant results of this study.

RADQ Scores According to Gender of the Child

There were no significant findings in relation to the total RADQ scores in regard to gender. The quasi-experimental group included nine boys and six girls and the control group consisted of nine girls and six boys, consequently, sample size appears to have

influenced findings that were not statistically significant. A larger sample size may have generated greater likelihood of statistically significant results.

RADQ Scores According to the Number of Placements

As indicated in Table 5, there were no significant findings in regard to the RADQ scores based on the number of placements experienced by the foster child. A lack of statistical significance appears to be related to the sample size and the disparity in the number of placements experienced by the foster children in the sample. In the quasi-experimental group, fourteen foster children had experience one placement and one foster child had experienced two foster placements. In the control group, five foster children had experienced one placement, nine foster children had experienced two foster placements, and one foster child had experienced three foster placements. A larger sample size may produce a wider range in the number of placements which has the potential to contribute to results that are statistically significant. In addition, research question five may have been a more effective question if the length of time in foster care had been considered instead of the number of placements experienced by the foster child. The length of time in placement may be a more significant factor to consider and may affect behaviors associated with attachment difficulty more significantly than the number of actual placements.

Limitations

Limitations in this research study appeared significant to the outcome of this research study. One such limitation involved the investigator's challenge of obtaining participants for both the experimental and control groups. Foster parents lead very busy lives and many individuals who expressed an interest in one group or the other were

ultimately unable to do so because of the time commitment involved. The quasi-experimental group especially was problematic in regard to time investment as participants had to commit to a three hour training session once a week for five weeks and to complete homework assignments that amounted to at least one additional hour per week. In addition, most foster parents were in need of child care services to make it feasible for them to attend either group. Because child care was not provided for CPRT or the Support Group, some foster parents were unable to participate. Two CPRT groups and one Support Group were conducted at a time when fuel prices were at a premium and travel cost may have impacted a foster parent's ability or inclination to participate.

It was especially difficult for the investigator to obtain participants in the control group; which appears related to the negative connotation that foster parents associated with the term "support group". It is possible that foster parents perceived participation in such a group as a form of weakness and connected to either mental health issues or an inability to handle the pressures of being a foster parent, especially in the East Tennessee geographic region.

The foster parents who did agree to participate in this research study were interested for a particular reason. Foster parents indicated the following motivations for participating in the quasi-experimental group: 1) to learn skills to help their foster children control their behavior; 2) to help themselves be better foster parents; 3) to more adequately prepare them for the issues they faced as foster parents of disturbed children or children with special needs; 4) to receive 15 hours of yearly training as mandated by the state; 5) to meet other foster parents; 6) because their case worker had recommended it to them; 7) to pursue the particular training that was advertised; 8) to learn something

new and different; 9) to transfer new skills to their current child care setting; and 10) to fulfill their hope to adopt their foster children at some point in the future and to be more bonded/attached to them. The hope of adopting their foster child and the potential for bonding appeared to be the primary motivations of the foster parents for participating in CPRT as twelve of the fifteen foster parents hoped to adopt.

Foster parents who participated in the control group indicated that following motivation for their participation: 1) they wanted to become more proficient foster parents for the benefit of the their foster children, other family members, the DHS system, and their community as a whole; 2) they were relatively new foster parents and hoped to become more familiar with the foster care program and more adapt at navigating the "system"; 3) they wanted to advocate for improved efficiency within the foster care program; 4) they had been foster parents for many years and believed they had something to offer the other members; 5) they had an interest in the social support offered by the group; 6) they had an interest in discussing issues related to mental health diagnoses that might affect their foster children; and 7) they wanted to learn strategies to effectively handle behavioral problems associated with diagnoses.

Some of the participants in both groups appeared interested in the group because they had access to a therapist who was familiar with issues pertaining to foster parenting and foster children in general. This presented a boundary issue for the investigator as she was frequently asked to play the role of therapeutic consultant. Regardless of motive for participating in either the quasi-experimental group or the control group, the fact that foster parents had particular interests related to the study may have confounded the results.

Another limitation that may have influenced the outcome of this research is the self-report nature of the CPRT training. The investigator had to accept that the foster parents in the quasi-experimental group accurately reported their actions in regard to play sessions and homework assignments. The investigator had to further believe that the foster parents conducted the CPRT play sessions with their foster children as prescribed by principles learned during training. Furthermore, the investigator had to presume that the foster parents accurately portrayed parental strengths and challenges when discussing them with the investigator and the CPRT group.

The self-report nature of the RADQ instrumentation used in this research may have also influenced the outcome of the study. Although the RADQ is precise in nature, it may not capture the subtle shifts in attitudes and perceptions of the foster parent. In addition, it was expected that the foster parents accurately reported their foster child's behaviors on the RADQ and neither overstated or understated the level of severity of these behaviors.

The investigator in this study also served at the CPRT trainer; consequently, it is important to consider the interaction effect of the investigator on the participants. This concern is related to issues that are intrinsic to socio-behavioral research. Walker, (2002) emphasized that acceptance of socio-behavioral scientific research requires the investigator to acknowledge that roles, values, ideologies, and philosophies play a part in research outcome but that by being cognizant of these variables and by using appropriate controls, it is still possible to arrive at valid conclusions. Although the investigator attempted to safe guard against subjective bias by adhering strictly to the research design, the joint role of researcher and trainer may have impacted the delivery of services and the

observations made by the investigator as she had both a research and clinical interest in the effectiveness of the CPRT intervention. Further research is needed to determine if utilizing CPRT to reduce behaviors associated with attachment difficulty will be statistically significant.

Landreth and Bratton's Goals of CPRT

Although the statistically significant results were limited in this study, comments made by foster parents who participated in CPRT, combined with the observations of the facilitator, support the use of CPRT with foster parents and foster children. Parents who participated in the quasi-experimental group indicated that they believed the majority of the goals established for parents by Landreth and Bratton (2006) were met through CPRT. These goals included 1) enhancing and strengthening the parent-child relationship; 2) facilitating a greater understanding of the child's emotional world; 3) developing of more realistic and tolerant perceptions and attitudes for self and the child; 4) parenting more effectively based on developmentally appropriate strategies; and 5) recapturing joy in parenting. Foster parents reported feeling emotionally closer to their foster child and an increased understanding of the motivation behind certain behaviors. In addition, they reported feeling less frustrated, being more in control of themselves, and less manipulate by their foster children. Foster parents indicated that they were most surprised by the fun they had with their foster child in their thirty-minute play sessions.

The investigator observed that participation in CPRT appeared to help foster parents develop a more adaptive relationship with their foster child, especially as it pertained to care-giving responses and a decrease in punitive behavior and power struggles. In addition, participation in CPRT appeared to help foster parents reduce their

stress level as they learned viable skills to use with their foster children to reduce problematic behaviors and as their challenges were validated and normalized by other foster parents experiencing the same issues.

Developing more realistic and tolerant perceptions of self was the goal that foster parents indicated was most problematic. Nearly all of the foster parents indicated that they believed that their expectations for themselves continued to be unrealistic subsequent to the CPRT training, although they indicated some improvement. Foster parents appeared hopeful that unrealistic expectations would diminish over time.

The foster parents in the quasi-experimental group indicated that they believed that participation in CPRT met more parental goals than child related goals. The child related goals of CPRT included 1) reduction of symptoms; 2) development of coping strategies, and 3) increase in positive feelings of self-worth and confidence. Time may be a factor in this perception as foster parents may have found it easier to detect changes in themselves as opposed to changes in their foster child. This may especially be true if the changes in the foster child are occurring internally and are less apparent short term. Although most foster parents indicated some reduction in their foster child's problematic behaviors and some increase in their self-worth, they did not indicate an increase in coping skills or self-confidence on the part of the foster child.

Most of the foster parents indicated that they noticed change in their foster child's behavior which resulted in a positive difference in their day to day interactions with their foster child. As indicated in Table 2, foster children in the quasi-experimental group did show a marginal reduction in delinquent and controlling behavior, however, the results were not significant at the *.05* level. As a result, CPRT shows promise as an intervention

that may diminish behaviors associated with attachment difficulties in foster children with attachment problems, and which shows potential in improving relationships between foster parents and foster children. Because most parents noted changes in their child's behavior during the course of CPRT, they indicated that they were motivated to continue to practice the skills that they learned and to continue therapeutic play session with their foster child subsequent to the training.

Anecdotal evidence acquired from comments made by foster parents who participated in CPRT and observations made by the facilitator support the use of CPRT with foster parents and foster children. Foster parents appeared to be effective therapeutic change agents in the lives of foster children. As a result, CPRT appears to be a practical and robust treatment option that can strengthen troubled foster care placements.

Recommendations for Practice

The results of this research study provide several implications for the counseling profession. First, there is a need for counselors to consider an integrated approach to Child and Family Therapy as this process has the potential to meet both the needs of foster children and the systemic demands of the foster family (Hutton, 2004). Second, CPRT is a treatment modality that can bring together the commonalties of Child and Family Therapy while producing desirable change in the broader family system. According to Guerney (1987), the initiator of filial therapy, a strong rationale for the integration of child and family therapy exists: 1) integration allows the referred child to be empowered as a full and equal participant of the family therapy process; 2) the methods utilized, in particular, play, allow the young child the opportunity to resolve personal conflicts and to develop self- control within the family sessions; 3) integration

promotes change from directly within the family system; and 4) change is achieved in an integrative and synergized manner that facilitates the likelihood that positive benefits will be maintained over time.

Treatment options for children with attachment issues may remain unchanged unless integrated therapies, such as CPRT, are accepted as a viable treatment option to the traditional approach of individual treatment over family intervention (Hutton, 2004). For the CPRT integrative approach to be successful, foster parents must be willing to extend their role to include not only the role of foster parent, but also the role of therapeutic change agent (Landreth, 2002). CPRT can help foster parents to develop new skills that can assist in relationship development and the minimization of problematic behaviors (Landreth & Bratton, 2006). CPRT offers foster parents and foster children assistance in the areas of bonding, anger management, and adjustment (Hutton, 2004). Foster parents learn skills to assist them in coping with behavioral problems and to intervene in a calm and decisive manner. These benefits can be maintained within the family unit thus facilitating long term advantages to all family members (Hutton, 2004).

Rennie and Landreth (2000), offered strong support for the use of filial therapy with children who had been abused and neglected. Children who have experienced maltreatment should be provided with a safe and supportive environment that can facilitate healing from trauma. Because reunification with the family of origin can require long periods of time, or is not always possible, children who have been abused and neglected may require foster care (Hutton, 2004). Positive foster parent and foster child relationships may contribute to resilience after maltreatment; consequently, an affirmative parent/child relationship may be a substantial part of recovery from abuse and

neglect (Ginsberg, 1989). In cases if maltreatment, CPRT offers the potential to enhance the adjustment process for the foster child and the foster family (Hutton, 2004).

CPRT is a home-based program, and as such, offers foster families flexibility for on-going support (Hutton, 2004). CPRT is a treatment option that can be modified to meet the individual needs of the foster family, the foster child, or the community service organizations that assist foster families. Home-based interventions offer foster family's flexibility that is not found in traditional treatment options (Hutton, 2004).

Recommendations for Future Research

Outcome studies support the efficacy of Filial Therapy and the CPRT model of Filial Therapy between parents and their children in various settings, across age, gender, marital status, and cultural and ethnic groups (Guerney, 1991; Glazer & Kottman,1994; Van Fleet, 1994; Bratton & Landreth, 1994; Chau & Landreth, 1997; Harris & Landreth, 1997; Bratton, Ray, & Moffit, 1998; Landreth & Lobaugh, 1998; Glover & Landreth, 2000; Jang, 2002; Landreth, 2002; Watts & Broaddus, 2002; Yuen, Landreth, & Baggerly, 2002; Bratton, Ray, Rhine, & Jones, 2005; Landreth & Bratton, 2006). No previous research was found that sought to determine if behaviors associated with attachment difficulty and attachment disruption can be diminished by participation in CPRT. Because of the limited nature of the findings in this study, additional research is needed to determine if CPRT can in fact offer hope for individuals with disrupted attachment. The following recommendations are offered for consideration in future research.

A replication of this study with foster parents and foster children may provide beneficial information regarding the effects of CPRT on behaviors associated with

attachment difficulty. Perhaps most significant to the success of such a study would be to use a larger number of participants in both the quasi-experimental group and the support group.

Varying the study to follow the 10- week model prescribed by Landreth and Bratton (2006) rather than the five-week model used in this study might demonstrate a decrease in problematic behaviors that did not previously show statistical significance. Foster parents may be more likely to participate in a group that met for one and a half hours per week rather than three hours per week and that spread the amount of homework over a ten week period of time.

A replication study may also consider the length of time in placement, in addition to or rather than the number of foster care placements, as a variable as the length of time in placement may provide more information about how behaviors associated with attachment difficulty are affected by time in care. In addition, such a study might further consider using a smaller age range by examining the effects of CPRT with children four to nine years of age. This might generate significant findings as younger children will not present with all of the behaviors measured by the RADQ, in particular delinquent and antisocial behaviors. Although discontinuing the two to three year old age range might prevent young children from receiving an intervention in their early years that may prevent later behavioral problems associated with attachment difficulty, a smaller age range may provide less variability.

Additional studies may consider comparing A CPRT foster group with a non-foster group regarding the impact of the CPRT intervention on behaviors associated with attachment difficulties of both groups. Birth parents might also be considered as a

population for future CPRT research if it is likely that the foster child will return to their family of origin.

Further research might assess the effectiveness of CPRT with adolescent foster children. Foster parents of adolescents often seek training to assist them with their foster child's problematic behaviors. Because CPRT has been used successfully with preadolescents to reduce problem behaviors (Packman & Solt, 2004), it is possible that CPRT may be helpful to foster parents of adolescents who wish to assist their foster children in diminishing problematic behavior.

Exploring the effects of CPRT on behaviors associated with attachment difficulty with individual foster parents rather than in a group format might be the focus of additional research. Some foster parents might benefit from the one-on-one attention such a format would provide. This arrangement might further ensure that the foster parents complete play sessions and homework assignments as prescribed by the training due to individual accountability.

Finally, additional research might include a longitudinal study to determine the long-term effects of CPRT with foster parents and foster children. In this manner, it can be determined if improvements in behaviors associate with attachment difficulties are maintained over time.

There is vast potential for CPRT to promote positive relationships between foster parents and foster children and to reduce problematic behaviors resulting from disruptive attachment. Future research may unlock this potential and improve the lives of vulnerable foster children.

Conclusion

CPRT is a practical and valid treatment option for foster parents because it offers educational opportunities in a supportive environment. It further offers foster parents the opportunity to develop skills such as active listening, therapeutic limit setting, and choice giving while communicating empathy and acceptance to their foster child. Our society is becoming more aware of the impact and implications of disrupted attachment on the individual, the family, and society as a whole. As a result, the need for effective interventions to address these issues increases. Because of the disrupted attachment experienced by foster children, foster parents may struggle with the problematic behaviors that accompany such disruption. CPRT offers foster parents and foster children hope that disrupted attachments need not prevent the foster child from developing into a happy, healthy, and well-adjusted member of society.

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APPENDICES

APPENDIX A

State of Tennessee Department of Children's Services Policy Planning and Research

Requests for Access to Human Subjects or Records, which may involve Informed Consent

Some research proposals require direct access to or observation of research subjects to gather data, or require access to records typically viewed as confidential. These research proposals require a higher level of scrutiny, as from an Institutional Review Board (IRB), which must examine additional issues such as informed consent and risks to the subject. In most cases, fully informed consent and minimal risk to the subject are mandatory elements, but there are a few grounds for exemption, which an IRB may consider (e.g., see CFR 46.101). Certain types of research cannot be allowed with children in DCS custody, even with consent, such as medical, pharmaceutical, or cosmetic experiments. If your proposed research project involves access to human subjects or access to confidential records, please complete the following (feel free to attach documents and write "see attached" as applicable):

Is this proposal: __ New ___X_ Amended ____ Addendum

Name and title of Principal Investigator:

Carolyn Carlisle Hacker, LPC, PhD Candidate

Credentials of Principal Investigator (or attach academic CV):

Licensed Professional Counselor, PhD Candidate (see CV Appendix A)

Title of Research Proposal:

Child-Parent-Relationship Therapy: Hope for Disrupted Attachment

Academic, Agency, or Institutional Affiliation:

The University of Tennessee

Address:

1122 Volunteer Boulevard, C448 Claxton Complex, Knoxville, TN 37996-3452

Phone: 865-974-3845

Does your agency have an established IRB in compliance with Title 45 of the Code of Federal Regulations, Part 46? __X__**Yes** ____**No**

If "Yes", please attach a copy of your IRB's approval or exemption of your proposed project.

IRB approval__(see Appendix H)_____

If "No", we **must** forward your proposal to another department to obtain review by their IRB **prior** to further consideration by the Department of Children's Services.

Names, titles, and credentials of Co-Investigators, research assistants, and others who will participate in the proposed study and/or have access to the data or subjects:

Tricia McClam, PhD; Associate Head, Educational Psychology and Counseling Department, University of Tennessee (supervising faculty)_____

Reason for proposed study: ____**X**___ Dissertation/Thesis ____Other student research ____Faculty research (funded) ____Other faculty research ____Pilot study/Demonstration Project

____Other (describe)_____

If sponsored research, list funding agency and grant number:__N/A_____

Purpose of study and proposed methodology: (or attach the introduction and methods sections used in a typical academic research proposal)

The intent of this quantitative study is to explore filial therapy, in particular the Parent-Child-Relationship Therapy (CPRT) model of filial therapy, as a method of intervention for foster children with attachment difficulties. The goal of this investigation is to determine if CPRT will affect the observed behaviors exhibited by foster children with attachment problems and if CPRT is an affective treatment for foster children with attachment difficulties. It is *not* the goal of this research to facilitate attachment between foster parents and foster children. Rather, the objective is to determine if CPRT is effective in reducing behaviors typically associated with attachment difficulties. Such a reduction in problematic behaviors may lead to improved relationships between the foster parent and the foster child thereby preventing disruptions in the foster child's placement.

Foster parents who are interested in helping their foster child address attachment problems and who meet criteria will be potential candidates for filial therapy. There are some clinical factors that would preclude the use of a filial therapy, for example, foster parents who are experiencing significant emotional distress or foster children whose emotional difficulties or behaviors are too extensive for the intervention at this time (Landreth & Bratton, 2006). Such participants interested in filial therapy would first be referred to individual therapy to address these issues. Foster parents and foster children who meet the following criteria would be viewed as viable candidates for filial therapy:

- The foster parent must be able to read and write on the 6th grade level
- The foster parent is willing to commit to the 5-Session Filial Therapy format

- The foster parent is willing to commit to two, thirty minute play sessions with their child two times per week during the filial therapy intervention
- The foster child is between the ages of two and nine years of age
- The foster child is able to engage in representational play
- The Intake process indicates that the foster parent and the foster child are appropriate candidates for filial therapy

Intervention

A Licensed Professional Counselor is the investigator of this study and is trained and experienced in play therapy and filial therapy techniques and will be supervised by University faculty. The investigator will conduct this research using the Landreth Child Parent Relationship Training Model (10-Session Filial Therapy Model). The investigator received training in the Landreth 10-Session Filial Therapy Model from Landreth and Bratton in the summer of 2006 and has practiced this technique since receiving formal training.

This model has been adapted from a 10-Session, one hour per week training program to a 5- Session, three hour per week training with documented success (Harris & Landreth, 1997). Consequently, this research will be modified to a 5-Session, three hours per week format to facilitate participation of the participants and to add to the research literature regarding the effectiveness of the 5-Session model.

Experimental Group

The investigator will conduct an initial assessment with interested participants in the experimental group to ensure that the foster parent and the foster child are candidates for filial therapy (Appendix B). Screening of the foster parent and foster child's background will be conducted with the investigator assessing if the foster parent and foster child meet criteria for CPRT using the above mentioned criteria. When the foster parent and foster child are considered candidates for filial therapy and when the foster parent agrees to participate with the permission of the State of Tennessee, the investigator will then explain the basics of the intervention and will answer any questions the foster parent may have regarding the process. The foster parents will be informed of a $25 cash incentive that will be given to participants after the 3rd session of CPRT. The participants will further be informed that they may discontinue participation at any time without penalty. If the participant has completed the 3rd session prior to discontinuing participation, they may keep the $25 cash incentive.

The investigator will present the Filial Therapy skills training program to the foster parents in a group format using a psycho-educational model. Each group will have a minimum of four participants and a maximum of eight participants to ensure maximum benefits from the group design (Landreth & Bratton, 2006). The goal is to recruit thirty participants to take part in this study (15 for the experimental group and 15 for the control). The therapists notebook (Appendix C), consist of the following critical teaching and training elements:

- Structuring for success
- Modeling acceptance, reflective listening and focused attention
- Fallibility of the therapist
- Encouraging parent strengths
- Utilizing specific instruction
- Providing concrete examples
- Imparting expert knowledge
- Encouraging role play and practice skills
- Using analogies to increase parent awareness
- Touching the inner world of the parent
- Making suggestions for improvement
- Identifying what is learned from special playtimes
- Identifying shifts or changes in behavior
- Facilitating insight
- Clarifying

The foster parents will be provided a Handbook for Parents that will serve as a detailed guideline for the process (Appendix D). The foster parents will be instructed in the basic skills of filial therapy and a variety of common problems that might develop during the process will be discussed with interventions role modeled by the therapist. Reflective listening skills, empathic responses, effective limit setting, handling interruptions, and commitment to the process are especially emphasized in this procedure. The foster parents will be taught the meaning of different play themes and how to respond to such themes in a caring and therapeutic manner. In addition, the investigator will assist the foster parents in choosing therapeutic toys for home sessions, setting up the play space, and structuring the play time within the home environment.

After the second session, the foster parents will begin to conduct therapeutic play sessions with their foster child in the home two times per week for thirty minutes per session. Subsequent to the five-week intervention, the foster parents will be encouraged to continue once a week CPRT in order to maintain the therapeutic relationship with their foster child.

Control Group

The investigator will conduct an initial assessment to ensure that the foster parent and foster child are candidates for participation in the control group (Appendix B). When the foster parent and foster child are considered candidates, and when the foster parent agrees to participate with the permission of the State of Tennessee, the investigator will then explain the basics of the support group and will answer any questions the foster parent may have regarding the support group process. The participants will further be informed that they may discontinue participation at any time without penalty.

Foster parents assigned to the control group will participate in a 5-Session support group that meets one time per week for one and a half hours per session. The foster parents are the only participants in the control group; the foster children will not be directly involved.

Instrumentation

A baseline assessment will be conducted as a pre-test measure using the Randolph Attachment Disorder Questionnaire (RADQ) for both the experimental and control groups (Appendix E). The Randolph Attachment Disorder Questionnaire (Randolph, 2000) is a self-report type measure that includes 30 items designed to assess attachment difficulties in children ages two to seventeen years of age. The RADQ will be completed by a foster parent who serves as the foster child's primary caretaker. This assessment instrument is a simple, straight forward questionnaire which can be easily completed by foster parents. This measure will ***not*** be used to diagnose an attachment problem; rather, it will be used to assess the extent to which Child-Parent- Relationship Therapy precipitates changes in problematic attachment behaviors. This instrument should never be used solely for the sake of attachment diagnosis (Randolph, 2000).

The Attachment Symptoms Checklist (ASCL) that was used for over 20 years in a residential program known as the Attachment Center in Evergreen, Colorado was the predecessor to the RADQ. This check list included commonly observed behaviors that children with attachment problems typically exhibit. The scale was developed through a pilot study (n=80) that utilized a 40 item attachment system checklist with children that had been diagnosed with no clinical diagnosis or with Attachment Disorder, or Conduct Disorder. The ASCL was revised into a 30 item inventory which became the Attachment Disorder Questionnaire Revised (ADQ-R). This inventory was then studied with children who had a history of maltreatment, diagnosis of Attachment Disorder and with children who had no history of maltreatment, Attachment Disorder or who were never involvement in therapeutic services (N=105). The final revision of the ADQ-R resulted in the development of the RADQ.

The RADQ examines five factors including: 1) delinquent behaviors, 2) social behaviors, 3) antisocial behaviors, 4) unstable behaviors, and 5) controlling behaviors (Randolph, 2000). Participants who complete the questionnaire use a 5-point rating scale to respond to the items on the questionnaire and represent the participant's perception of the child's behavior and or traits. A score of one represents rarely, less than 10% of the time; a score of two represents occasionally, about 25% of the time; a score of three represents sometimes, occasionally present; a score of four represents often, 75% of the time; and a score of five represents usually, 90% of the time. The instrument is scored by adding a cumulative score minus 30 points in order to determine the level of attachment difficulty. A score of 65–75 would indicate a mild form of attachment difficulty associated with an avoidant or anxious sub-type of attachment difficulty; a score of 76–89 would indicate a moderate degree of attachment difficulty; and a score of 90 and above would indicate severe attachment difficulties and associated with an ambivalent sub-type of attachment difficulty.

The RADQ is a published instrument with reliability and criterion-referenced, construct, content, and predictive validity reported (Fairchild, 2006, Randolph, 2000). Test–retest correlation coefficients of .82 for the Attachment Disorder group, and .85 for the non-clinical group were reported regarding reliability. Cronbach's alpha for internal consistency measures for the Attachment Disorder group were .84; .81 was indicated for the maltreated group, which indicate internal consistency for the RADQ (Randolph, 2000). Construct validity was determined by correlating scores on the RADQ with sub-scales in three other published instruments. The Personality Inventory for Children (PIC), indicated two subscales out of six were statistically significant including delinquency ($r = .48$, $p<.001$). The Child Behavior Checklist (CBCL) yielded two out of eight statistically significant subscales including delinquent behavior, $r = .36$, $p<.01$, and the Millon Adolescent Personality Inventory (MAPI) indicated that one subscale out of 12 was statistically significant, personal esteem, $r = .37$, $p<.01$. The correlation between the RADQ and these three standardized instruments was determined through a pre- and post-treatment of clients at the Evergreen Attachment Center (Fairchild, 2006). A replication study by Myeroff, Mertlich & Gross (1999) corroborated the effectiveness of this assessment measure's effectiveness.

Research Questions and Data Analysis

Following the completion of the 5-Session CPRT intervention, the foster parents will complete a post-test of the Randolph Attachment Disorder Questionnaire. The pre-test and post-test scores of the experimental group will be compared to the pre-test and post-test scores of the control group using a Two-way Repeated Measures ANOVA for the following questions: (1) Will the experimental group score significantly lower ($p< .05$) on the RADQ than the control group, and (2) Is CPRT an effective treatment for foster children with attachment difficulties? The pre-test and post-test scores of the experimental group will be compared to the pre-test and post-test scores of the control group using a Three-Way Repeated Measures ANOVA for the following questions: (1) will the age of the foster child be a factor in determining the effects of CPRT in reducing behaviors associated with attachment difficulties?, (2) Will the gender of the foster child be a factor in determining the effects of CPRT in reducing behaviors associated with attachment difficulties?, and (3) Will the number of foster homes a child has been placed in be a factor in determining the effects of CPRT in reducing behaviors associated with attachment difficulties? The level of significance between the pre-test and post-test scores of the experimental group and the control group will be measured to determine the overall efficacy of the intervention in regard to the different independent variables.

Describe in detail specifically what you plan to do with the subjects in your study (be sure to attach copies of any forms, tests, questionnaires, etc. you plan to administer), and/or what confidential records you wish to access. Include a discussion of any risks, discomforts, or inconveniences, which a subject might experience

Experimental Group

The investigator will conduct an initial assessment with interested participants to ensure that the foster parent and the foster child are candidates for filial therapy (Appendix B). Screening of the foster parent and foster child's background will be conducted with the investigator assessing if the foster parent and foster child meet criteria for CPRT using the above mentioned criteria. When the foster parent and foster child are considered candidates for filial therapy and when the foster parent agrees to participate with the permission of the State of Tennessee, the investigator will then explain the basics of the intervention and will answer any questions the foster parent may have regarding the process. The foster parents will be informed of a $25 cash incentive that will be given to participants after the 3rd session of CPRT. The participants will further be informed that they may discontinue participation at any time without penalty. If the participant has completed the 3rd session prior to discontinuing participation, they may keep the $25 cash incentive.

The investigator will present the Filial Therapy skills training program to the foster parents in a group format using a psycho-educational model. Each group will have a minimum of four participants and a maximum of eight participants to ensure maximum benefits from the group design (Landreth & Bratton, 2006). The goal is to recruit thirty participants to take part in this study. The therapists notebook (Appendix C), consist of the following critical teaching and training elements:

- Structuring for success
- Modeling acceptance, reflective listening and focused attention
- Fallibility of the therapist
- Encouraging parent strengths
- Utilizing specific instruction
- Providing concrete examples
- Imparting expert knowledge
- Encouraging role play and practice skills
- Using analogies to increase parent awareness
- Touching the inner world of the parent
- Making suggestions for improvement
- Identifying what is learned from special playtimes
- Identifying shifts or changes in behavior
- Facilitating insight
- Clarifying

The foster parents will be provided a Handbook for Parents that will serve as a detailed guideline for the process (Appendix D). The foster parents will be instructed in the basic skills of filial therapy and a variety of common problems that might develop during the process will be discussed with interventions role modeled by the therapist. Reflective listening skills, empathic responses, effective limit setting, handling interruptions, and commitment to the process are especially emphasized in this procedure. The foster parents will be taught the meaning of different play themes and how to respond to such themes in a caring and therapeutic manner. In addition, the investigator will assist the

foster parents in choosing therapeutic toys for home sessions, setting up the play space, and structuring the play time within the home environment.

After the second session, the foster parents will begin to conduct therapeutic play sessions with their foster child in the home two times per week for thirty minutes per session. Subsequent to the five-week intervention, the foster parents will be encouraged to continue once a week CPRT in order to maintain the therapeutic relationship with their foster child.

Control Group

The investigator will conduct an initial assessment to ensure that the foster parent and foster child are candidates for participation in the control group (Appendix B). When the foster parent and foster child are considered candidates, and when the foster parent agrees to participate with the permission of the State of Tennessee, the investigator will then explain the basics of the support group and will answer any questions the foster parent may have regarding the support group process. The participants will further be informed that they may discontinue participation at any time without penalty.

Foster parents will participate in a 5- Session, one and a half hour per session control group that will be structured in a support group format that will consist of four to ten other foster parents. The foster parents are the only participants in the control group; the foster children will not be directly involved. This support group will provide an opportunity for foster parents to discuss and process the challenges of being a foster parent with others who are experiencing similar challenges and successes. In addition, this support group will provide a forum for accessing resources available to foster parents and foster children and for addressing and promoting quality foster care.

Foster parents will complete a Randolph Attachment Disorder Questionnaire that asks questions about the foster child's behavior. This instrument will be completed before the support group begins and again after the 5-week support group is concluded. This instrument will in *no way* be used to make an attachment diagnosis of any kind, rather, it will be used to assess the extent to which Child-Parent- Relationship Therapy effects changes in problematic attachment behaviors and whether or not CPRT is an effective treatment intervention for foster children with attachment problems.

Describe how you propose to recruit research subjects and obtain their informed consent, and in cases of children under the age of eighteen, their parent(s) or guardian. Be sure to attach a copy of your proposed consent form. If claiming exemption from consent requirements, discuss the regulatory basis under which your IRB granted the exemption

Recruitment of Participants

The participants in this study will be foster parents and foster children from the Knox, Smokey Mountain, and East regions of Tennessee who have permission from the State of Tennessee for the foster child to participate in this investigation. The primary participant

will be the foster parents although the foster children will be an indirect participant in the experimental group. The foster children in the control group will not be participants in this research. The investigator will recruit participants through contacts made with the Department of Children's Services (DCS) Child Protective Services (CPS) and through contacts made with regional health unit psychologists, and foster care programs that will help identify potential participants. CPS caseworkers, regional health unit psychologists, and foster care programs in these three regions will be given brochures to give potential participants (Appendix F, experimental group) (Appendix G, control group). The investigator's work phone number and email address will be included on the brochures so that interested foster parents may contact the investigator. In addition, the investigator will meet with caseworkers, regional health unit psychologists, potential participants, and foster parent organization meetings to discuss the groups being offered and to answer any questions the parties may have.

Obtaining Informed Consent

The investigator will explain the basics of the intervention or control group and will answer any questions the foster parent may have regarding the process. The foster parents participating in the experimental group will be informed of a $25 cash incentive that will be given to participants after the 3rd session of CPRT. The investigator will explain informed consent to the participants (Appendix I Experimental Group) (Appendix J Control Group) which includes that they may discontinue participation at any time without penalty. If the participant in the experimental group has completed the 3rd session prior to discontinuing participation, they may keep the $25 cash incentive.

Foster parents that are interested in participating in this study will sign two copies of the above mentioned informed consent document; one copy will be given to the participant and one copy will be securely filed at the University of Tennessee.

Describe the specific data and variable fields you plan to access and record: (can attach your codebook or coding schema if already developed)

Pre-test and post test scores of the RADQ will be collected for each participant in either the experimental group or the control group. The pre-test and post-test scores of the experimental group will be compared to the pre-test and post-test scores of the control group using a Two-way Repeated Measures ANOVA for the following questions: (1) Will the experimental group score significantly lower ($p < .05$) on the RADQ than the control group, and (2) Is CPRT an effective treatment for foster children with attachment difficulties?
The pre-test and post-test scores of the experimental group will be compared to the pre-test and post-test scores of the control group using a Three-Way Repeated Measures ANOVA for the following questions: (1) will the age of the foster child be a factor in determining the effects of CPRT in reducing behaviors associated with attachment difficulties?, (2) Will the gender of the foster child be a factor in determining the effects of CPRT in reducing behaviors associated with attachment difficulties?, and (3) Will the number of foster homes a child has been placed in be a factor in determining the effects

of CPRT in reducing behaviors associated with attachment difficulties? The level of significance between the pre-test and post-test scores of the experimental group and the control group will be measured to determine the overall efficacy of the intervention in regard to the different independent variables.

Describe how subject anonymity will be preserved and how confidentiality of the data will be maintained: What materials, staff time, and other resources will you require DCS to provide for you to accomplish your proposed project?

Participants will use a pseudonym that they assign to themselves on any instrumentation or written documents to ensure confidentiality. The investigator will not use the participants name in any written results of the study. Furthermore, informed consent documents will be stored in a locked file in the office of supervising staff on the University of Tennessee campus. A list of assigned pseudonyms will be stored in a separate locked file in the supervising staff's office. In addition, all instrumentation documents will be stored in a further separate locked file and located in the same supervising staff member's office on the University of Tennessee campus. To adhere to the University of Tennessee's Institutional Review Board policy, all documentation pertaining to this study will be safely stored during the study. The signed consent form will be stored for three years subsequent to the study. All other documents and instrumentation will be destroyed after six months.

Minimal DCS materials, staff time and other resources will be needed to accomplish this project. The investigator would need to meet briefly with support staff to obtain contacts for recruiting participants. This may also include brief email and or phone contact with DCS staff for such recruitment purposes. All materials needed for the experimental group or the control group will be provided by the investigator.

Please describe how your proposed research project would be of benefit to each of the following: the research subjects, the Department of Children's Services, the children of this state and/or children within DCS programs, the state of Tennessee, the citizens of this state, advancement of scientific and human knowledge:

Participation in this study will add to the body of knowledge regarding the effectiveness of filial therapy to diminish behaviors associated with attachment difficulties in foster children with attachment problems. Additional benefits may be derived from an improved relationship between the foster parent and the foster child which may minimize disruptions in the foster child's placement. In addition, presenting behavioral problems exhibited by the child may also be decreased or extinguished. Secondary benefits may also result if improved relationships are generalized to the biological parent, thus improving the relationship between the parent and the child. In addition, benefits may also result if improvements are generalized to other settings such as social relationships, school settings, etc. A further benefit may be derived to foster children, the Department of Children's Services and society as a whole if improved relationships between the foster parent and the foster child prevent disruptions in the foster child's placement.

Minimal risk to participants is expected due to the nature of the filial therapy intervention, i.e., a psycho-educational format and the participant's ability to decide the nature of their responses during the course of the study. However, the participant may experience emotional discomfort related to difficulties with parenting their foster children or as a result of the foster child's behavioral problems or from initiating play sessions with their foster child. There is a possibility that the foster child may experience some emotional discomfort when participating in play sessions with their foster parent although this would not be common. Although minimal risk is expected, the investigator will assess for any potential risk to the participants and will provide foster parents with a list of qualified helping professionals that they can contact in their geographical area should the need arise.

If your proposal is approved, once you have completed collecting the data, describe your plans for quantitative and/or qualitative data analysis: (please provide sufficient detail that a reviewer could examine the appropriateness of your approach)

Quantitative Data Analysis

Prior to the CPRT intervention, foster parents will complete a pre-test of the Randolph Attachment Disorder Questionnaire (RADQ). Following the completion of the 5-Session CPRT intervention, the foster parents will complete a post-test of the Randolph Attachment Disorder Questionnaire. The pre-test and post-test scores of the experimental group will be compared to the pre-test and post-test scores of the control group using a Two-way Repeated Measures ANOVA for the following questions: (1) Will the experimental group score significantly lower ($p < .05$) on the RADQ than the control group, and (2) Is CPRT an effective treatment for foster children with attachment difficulties? The pre-test and post-test scores of the experimental group will be compared to the pre-test and post-test scores of the control group using a Three-Way Repeated Measures ANOVA for the following questions: (1) Will the age of the foster child be a factor in determining the effects of CPRT in reducing behaviors associated with attachment difficulties?, (2) Will the gender of the foster child be a factor in determining the effects of CPRT in reducing behaviors associated with attachment difficulties?, and (3) Will the number of foster homes a child has been placed in be a factor in determining the effects of CPRT in reducing behaviors associated with attachment difficulties? The level of significance between the pre-test and post-test scores of the experimental group and the control group will be measured to determine the overall efficacy of the intervention in regard to the different independent variables.

If approved, once your research is completed, what do you intend to do with your results? What agencies might receive and/or benefit from receipt of your results? What types of scientific journals or publications might your findings be submitted to for review? Optional (response will not affect approval):

It is the investigator's intent to submit research results to the International Journal of Play Therapy to be considered for publication.

If your project yields an electronic data base (e.g. raw data stored on computer disc, an SPSS system file, etc.), will you make available to DCS a copy for purposes of secondary data analysis?

__X__**Yes** ____**No** ____**Not Applicable**

Your signature below indicates that you agree to abide by the following four requirements:

- You agree to furnish DCS a copy of your findings, conclusions, final report, and/or journal articles **prior to** publication or dissemination, as required by ACA standards (Note: this does not imply you need DCS permission to publish your results, only that you first furnish DCS a copy for purposes of review and comment);

- You agree to obtain written permission from DCS before sharing the raw data or data base with anyone other than DCS and the above listed research team members (Note: this applies only to the data and is not intended to prevent or interfere with publishing the **results** of your research project in a customary format such as group statistics which do not identify individual subjects);

- You and your staff agree to abide by all appropriate state laws and federal regulations regarding confidentiality of any data/records you access, review, obtain, or maintain in the course of conducting this research;

- In the event a participant has an adverse reaction as a result of participating in the study, you and your staff agree to promptly notify the appropriate DCS supervisor of that facility and the Director of Policy and Planning.

Principal Investigator: Carolyn Carlisle Hacker **Date**: 7/11/08

References

Fairchild, S., (2006). Understanding Attachment: Reliability and Validity of Selected Attachment Measures for Preschoolers and Children. *Child and Adolescent Social Work Journal,* 23 (2) p. 235 – 261.

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Harris, Z., & Landreth, G. (1997). Filial Therapy with Incarcerated Mother: A Five Week Model. International Journal of Play Therapy, 6(2), 53-72.

Randolph, E. (2000). *Manual for the Randolph Attachment disorder Questionnaire. Evergreen,* CO. The Attachment Center Press.

Carolyn Carlisle Hacker L.P.C.

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EDUCATION

8/2005 – Present PhD Candidate, Counselor Education Program, University of Tennessee, Knoxville, Tennessee; 4.0 GPA; anticipated graduation, August 2008.

1/2004 – 8/2004 Post-Graduate Courses, University of Tennessee, Knoxville, Tennessee; 4.0 GPA

8/1994 – 5/1995 Post-Graduate Courses, Licensed Professional Counselor, Texas A&M University, Corpus Christi, Texas; 4.0 GPA

8/1991 – 5/1994 Master of Science, Counseling Psychology, Texas A&M University, Corpus Christi, Texas; 4.0 GPA

8/1975 – 5/1979 Bachelor of Science, Recreation and Park Administration, Texas A&M University, College Station, Texas; Minor, Psychology; Specialization, Therapeutic Recreation

LICENSES & CERTIFICATES

- License Professional Counselor, Texas (Eligible for licensure in Tennessee)
- Board Certified Professional Counselor, American Psychotherapy Association
- Certified Cognitive Behavioral Therapist, National Board of Cognitive Behavioral Therapists
- Certified Forensic Counselor, National Board of Forensic Counselors
- Certified Domestic Violence Counselor, National Board of Cognitive Behavioral Therapists

WORK HISTORY

Teaching Experience

6/2008 – Present *Assistant Professor of Psychology, Carson-Newman College*
Instructor of undergraduate students; planned, organized, and implemented lesson plans,; developed syllabi, direct oversight for all aspects of teaching of four classes per semester including use of technology, development of Blackboard website, use of portfolio, and oversight of the Undergraduate Research Conference; classroom learning was conducted via experiential learning and authentic tasks as per constructivist theory; facilitated learning in the areas of developmental psychology across the life span, adult development, child development, forensic psychology, play therapy, and counseling theory and techniques; facilitated critical thinking, application of learning principals, personal, social, emotional, and cognitive development of students; included ethics, and recognizing, reporting and preventing child

abuse in class content; participated in departmental decisions making, textbook selection. Advisor of 16 students, mentor of two students.

9/2005 – 5/2008 *Graduate Teaching Associate – University of Tennessee*
Instructor, Educational Psychology 401, Applied Educational Psychology; lead instructor for one section in the fall and two sections in the spring under the supervision of Dr. Katherine Greenberg; instructed both undergraduate and master's level students; developed syllabi according to state standards; direct oversight for all aspects of the class including use of technology, development of Blackboard website, on-line exams, and use of on-line portfolio, conducted research regarding online learning; use of presentation tools including software; use of experiential learning and authentic tasks as per constructivist theory; conducted dispositions; facilitated learning in the areas of critical thinking, learning theory, classroom management, motivation, assessment, learner differences, personal, social, emotional, and cognitive development, ethics, recognizing, reporting and preventing child abuse, and protecting teachers from allegations of sexual misconduct; prepared teacher education students for PRAXIS exam.

Supervision Experience

1/2006 – 5/2006 PhD Internship - Supervision of master level school counselor students at the University of Tennessee during their practicum experience in the areas of counseling skills development, treatment planning and implementation, counseling theoretical orientation, ethics, documentation, advocacy, reporting suspected child abuse, and play therapy.

9/2004 – 10/2005 Direct oversight for the supervision of master level LPC interns at the Sexual Assault Crisis Center in the areas of clinical skills development, diagnosis, treatment planning and implementation, case conceptualization, staffing, documentation, ethics, play therapy, forensic therapy, and advocacy.

4/2004 – 3/2005 Supervision of master level social work interns at the Sexual Assault Crisis Center in the areas of clinical skills development, diagnosis, case conceptualization, treatment planning and implementation, staffing, documentation, ethics, play therapy, forensic therapy, and advocacy.

9/2002 – 4/2004 Supervision of bachelor level social work interns at the Sexual Assault Crisis Center in the area of advocacy with victims of sexual assault; documentation, and resource and referral.

Clinical Experience

2/2005 – 5/2007 **Family Services Counselor – East Tennessee State University**
Career counseling with Families First clients though the Department of Human Services, Wartburg, TN; assessed client's vocational interests, work histories, strengths, and academic abilities; helped clients develop strategies for successfully obtaining employment; referred clients to GED, vocational, and university programs when appropriate; assisted clients in completing paperwork associated with educational programs and social security disability applications; referred

clients to educational testing when appropriate; addressed issues to help client overcome barriers to employment such as Depression, Anxiety Disorder, Bipolar Disorder, Attention Deficit Hyperactivity Disorder, and Posttraumatic Stress Disorder; primary theoretical orientation, Cognitive Behavioral Therapy and Brief Solution Focused Therapy

9/2005 – 12/2005 **PhD Practicum - Office of the Public Defender – Knoxville, Tennessee**
Psychotherapy with incarcerated clients; case conceptualization, treatment planning and implementation; addressed issues related to Depression, Anxiety Disorder, Bipolar Disorder, Attention Deficit Hyperactivity Disorder, Posttraumatic Stress Disorder, Schizophrenia, grief and loss, substance abuse; referral to inpatient programs, group homes, job placement, and housing resources; career counseling; primary theoretical orientation, Cognitive Behavioral Therapy

6/2002 – 2/2005 **Psychotherapist – Sexual Assault Crisis Center, Knoxville, Tennessee**
Psychotherapy with children, adults, adolescents, families, and foster families to address issues related to sexual abuse, Posttraumatic Stress Disorder, Adjustment Disorder, Bipolar Disorder, Schizophrenia, Depression, Dissociative Identity Disorder, domestic violence, substance abuse, Attention Deficit Hyperactivity Disorder, attachment issues, grief and loss, Oppositional Defiant Disorder, and career counseling; conducted play therapy, and forensic abuse assessments and interviews; developed and implemented master treatment plans and submitted documentation regarding treatment; participated in case conceptualization, case staffing and interdisciplinary approach to assisting clients; provided court testimony and child advocacy; provided training and consulting with other agencies; supervised interns.

8/1998 –10/2001 **Psychotherapist - Private Practice, San Antonio, Texas**
Psychotherapy with adults, adolescents, children, groups, families, and foster families to address issues related to physical, sexual and emotional abuse (victims and non-offending spouses), Oppositional Defiant Disorder, Attention Deficit Hyperactivity Disorder, attachment issues, adoption, grief and loss, domestic violence, substance abuse, and career counseling; conducted play therapy, filial therapy, and forensic interviews; developed and implemented master treatment plans; submitted documentation regarding treatment and other required paperwork associated with contracts, Medicaid or other insurance claims; participated in case staffing, case conceptualization, and interdisciplinary approach to assisting clients; provided court testimony, child advocacy, training and consulting.

8/1997 – 8/1998 **Counselor, Alamo Children's Advocacy Center, San Antonio, Texas (LPC Intern)**
Provided short-term crisis counseling to children and adolescents that had been sexually abused or sexually assaulted; provided short-term crisis counseling to family members of sexual abuse/sexual assault victims; provided long term counseling of children and adolescents that had been sexually abused/sexually assaulted; conducted forensic interviews and initial assessments; conducted psychosocial assessments and developed and implemented master treatment plans; documented all counseling sessions

with clients; facilitated client intake; scheduled client appointments; referred clients to other organizations for a variety of needs including medical, financial, housing, mental health, etc.; helped clients access victims of crime funding; acted as a liaison between the Center and other agencies to include the Department of Protective and Regulatory Services, District Attorney's Office, Law Enforcement, schools, etc.; assisted medical personnel with examinations when necessary; facilitated community education in the area of child sexual abuse; tracked clients to ensure appropriate services were provided.

1/1997 – 8/1997 **Clinical Director/Therapist, Youth Habitat of Texas, Inc., Kerrville, Texas / Boerne Texas (LPC Intern)**
Direct oversight of mental health services provided to residents within the residential treatment centers; ensured mental health services were in compliance with state guidelines; conducted admission assessments of all incoming residents; supervised personnel including four psychotherapists and 23 direct care staff; trained personnel in the areas of adherence to master treatment plans, client capabilities, behavior modification, positive reinforcement, use of token economy, state licensure requirements, appropriate discipline and positive guidance; provided long-term therapy to severely emotionally disturbed male children ages five to 18 utilizing a variety of techniques including play therapy, individual therapy, recreation, and group therapy, as well as career counseling; conducted psychosocial assessments; developed and implemented master treatment plans; prepared documentation for Youth for Tomorrow reviews; provided documentation of therapy conducted; ensured incident reports were completed; requisitioned and purchased therapy supplies; served as a liaison between the organization and other agencies including DPRS, juvenile justice, schools, etc.; provided court testimony.

Early Childhood Education Experience

3/1989 – 9/1996 **Child Development Program Administrator, US Naval Civil Service, Corpus Christi, Texas**
Direct management of the Child Development Center, Pre-Kindergarten, and Family Childcare Program at Naval Air Station, Corpus Christi, Texas that provided care and early childhood education to over 250 children; supervised 40 personnel; fiscal management of $900k annual budget; operated a comprehensive Resource and Referral system referring parents to a variety of support services; provided an Early Childhood Educational Curriculum; developed, implemented, and facilitated training of staff and parents pertaining to the mental and physical well being of children; developed and implemented behavioral modification programs.

RESEARCH

Carlisle, C. (2004) Single Participant Research to Facilitate Attachment Utilizing Filial Therapy (Unpublished).

Carlisle, C. (2007). *An Invitation to Connection: Child Parent Relationship Therapy with an Appalachian Parent and Child* (Research Competency, Submitted for publication to the International Journal for Play Therapy, January, 2008).

Lester, J., Evans, K., Williams, M., Hacker, C., Halic, O. (2007). The Impact of Traditional, In-Class and Online, Learner-Centered Exams on Student Learning (Anticipated date of submission, August 2009).

Hacker, C. (2008) *Child Parent Relationship Therapy: Hope for Healing Disrupted Attachments* (Dissertation, anticipated date of completion, August 2009).

INTERNATIONAL PRESENTATION

Hacker, C., Halic, O., (2007). *The Impact of Traditional, In-Class and Online, Learner-Centered Exams on Student Learning.* Presented at the International Association for Cognitive Education and Psychology Annual Meeting, Knoxville, TN, July 2007.

NATIONAL PRESENTATION

Hacker, C., Halic, O., (March 2008). *The Impact of Traditional, In-Class and Online, Learner-Centered Exams on Student Learning.* Presentation to be presented at the American Educational Research Association Annual Meeting, New York, New York.

STATE PRESENTATION

Hacker, C**.** (March, 2008). *An Invitation to Connection: Child-Parent-Relationship Therapy with an Appalachian Parent and Child.* Presented at the Graduate Student Colloquium, University of Tennessee, Knoxville, Tennessee.

STATE AND LOCAL TRAININGS

Hacker, C. (September, 2006). *Assessing Allegations of Sexual Abuse in Young Children*. Presented at Smokey Mountain Counselors Association Annual Conference, Knoxville, Tennessee.

Hacker, C. (March, 2006). *"It's a Jungle out There", Institutional Abuse Prevention curriculum for the Helping Professional.* Presented to DHS caseworkers in Morgan County, Tennessee.

Hacker, C. (January, 2006). *Sexual Abuse and the Healing Process*. Keynote Address Presented by Invitation, Prevent Child Abuse Texas Annual Conference, Dallas, Texas.

Hacker, C. (January, 2006). *Assessing Allegations of Sexual Abuse in Young Children*. Presented at Prevent Child Abuse Texas Annual Conference, Dallas, Texas.

Hacker, C. (April, 2005). *Assessing Allegations of Sexual Abuse in Young Children*. Presented to counselors and therapists with East Tennessee State University, Family Service Counseling, Knoxville, Tennessee.

Hacker, C. (October, 2004). *Basic Psychopharmacology for the Play Therapist*. Presented to counselors in East Tennessee through the Sexual Assault Crisis Center.

Hacker, C. (August, 2004) *Recognizing, Reporting and Preventing Child Abuse in Youth Development Settings*. Presented to staff at the S.O.A.R. Youth Program, Knoxville, Tennessee, and Girl's Inc., Oak Ridge, Tennessee.

Hacker, C. (July, 2004). *The Play Therapist Goes to Court*. Presented to counselors in East Tennessee through the Sexual Assault Crisis Center.

Hacker, C. (April, 2004). *Discovering and Responding to Themes in Play Therapy*. Presented to counselors in East Tennessee through the Sexual Assault Crisis Center.

Hacker, C. (January, 2004). *An Introduction to Play Therapy*. Presented to counselors in East Tennessee through the Sexual Assault Crisis Center.

Hacker, C., MacDonald, P. (August, 2003). *The Impact of Sexual Assault*. Presented to City of Knoxville Police Department in conjunction with the Sexual Assault Crisis Center.

Hacker, C. (March, 2003). *Assessing Allegations of Sexual Abuse in Young Children*. Presented to Sexual Abuse Crisis Center counselors and therapists, Knoxville, Tennessee.

Hacker, C. (August, 2002). *"It's a Jungle out There", Institutional Abuse Prevention curriculum for the Helping Professional.* Presented to Sexual Assault Crisis Center volunteers and staff in Knoxville, Tennessee.

Hacker, C., MacDonald, P. (August, 2002). *The Impact of Sexual Assault*. Presented to City of Knoxville Police Department in conjunction with the Sexual Assault Crisis Center.

Hacker, C. (2001). *Assessing Allegations of Sexual Abuse in Young Children*. Presented at Prevent Child Abuse Texas Annual Conference, San Antonio, Texas.

Hacker, C. (August, 2000). *Preventing Child Sexual Abuse in the Faith Community.* Presented at the Texas Baptist Association Annual Meeting, San Antonio, Texas.

Hacker, C. (January 2000). *Preventing Child Sexual Abuse in the Faith Community.* Presented at Prevent Child Abuse Texas Annual Conference, Austin, Texas.

Hacker, C. (March, 1998). *"It's a Jungle out There", Institutional Abuse Prevention curriculum for the Helping Professional.* Presented to DHS caseworkers in Bexar County Texas, Atascosa County Texas.

Hacker, C. (January, 1998). *Recognizing, Reporting and Preventing Child Abuse in Child Development Center and Family Home Care Settings.* Presented at Prevent Child Abuse Texas Annual Conference, Austin, Texas.

CONSULTATION

1998-2002 Forensic Consultation, Department of Human Services, Bexar County Texas, Atascosa County Texas

1998-2002 Forensic Consultation, Court Appointed Special Advocates (CASA), Bexar County, Texas

2002-2005 Forensic Consultation, Safe Haven, Knoxville, Tennessee

2002-Present Play Therapy; Filial Therapy, Safe Haven, Knoxville, Tennessee

1995-Present Abuse Prevention Consultation and Curriculum Development, Prevent Child Abuse Texas, Austin, Texas

PROFESSIONAL AFFILIATIONS

- Member National Association of Cognitive Behavioral Therapists 1998 - Present
- Member National Association of Forensic Counselors 1998 - Present
- Member Smoky Mountain Counseling Association 2005 - Present
- Member Tennessee Counseling Association 2005 – Present
- Member Chi Sigma Iota Counseling Honor Society 2005 – Present
- Member Phi Kappa Phi Honor Society 2006 – Present
- Member Psi Chi Psychological Honor Society 1993 - Present
- Member**,** Tennessee Coalition to Prevent Domestic and Sexual Violence, 2002 - Present
- Member, Board of Directors, Prevent Child Abuse Texas, Austin Texas 1995 - 2001
- President Elect, Prevent Child Abuse Texas, Austin Texas 2000 - 2001

GRANT WORK

1995 Assisted Nueces County children's advocacy initiative to solicit funding for a children's advocacy center; awarded $90,000 by the Charity League, Corpus Christi, TX.

VOLUNTEER WORK

1998-2002 Curriculum development for Prevent Child Abuse Texas; Recognizing, Reporting and Preventing Child Abuse in a Child Development Center Setting and in a Family Home Care setting, Preventing Child Sexual Abuse in the Faith Community, and Assessing Allegations of Sexual Abuse in Young Children currently available nationwide

State of Tennessee IRB Approval

STATE OF TENNESSEE
DEPARTMENT OF CHILDREN'S SERVICES
7th Floor, Cordell Hull Building
436 6th Avenue North
Nashville, TN 37243

July 17, 2008

Carolyn Carlisle Hacker
102 Briarwood Drive
Oak Ridge, TN 37830

Dear Ms. Hacker

We are pleased to inform you that your research proposal entitled"Child-Parent-Relationship Therapy: Hope for Disrupted Attachment" has been approved by the Department of Children's Services. All previously agreed upon conditions (full disclosure, releases, etc.) and protocols must be strictly adhered to, and the Department must first approve any changes to the research effecting agreed upon terms.

As required by DCS policy and the ACA standards, you are required to submit a copy of your final results or reports prior to their publication or dissemination. This does not mean you need DCS' permission to publish or disseminate your results, or that we would attempt to censor any findings. The standard only states that the effected administrators have an opportunity to first review and comment on the results.

Good luck with your project. Please feel free to contact me if you have any questions or require additional assistance at (615) 532-7332.

Sincerely,

Eric Henderson
Executive Assistant, Department of Children's Services

cc: Deputy Commissioner Tom Riche

APPENDIX B

Child-Parent-Relationship Therapy Brochure

Child-Parent Relationship Training for Foster Parents
Give your foster children what they need most: YOU

When foster children have problems, sometimes they don't have the words to talk about them. Play gives children a way to communicate feelings they don't understand or can't express any other way.

Play therapy has been shown to be an effective intervention with children for a variety of behavioral and emotional difficulties. Research has shown that motivated foster parents can be trained to be as effective as play therapists using play therapy skills with their own foster children, with as little as 15 hours of **Child-Parent-Relationship Therapy Training**.

Research studies have shown that Child-Parent-relationship Training can:

- Reduce or eliminate behavior problems
- Enhance the parent-child relationship and the marital relationship
- Develop responsibility and self-control in children
- Increase children's self-esteem and self-confidence
- Increase parent' feelings of warmth for their children

Child-Parent-Relationship Therapy Training is conducted in five weekly, three hour sessions. The atmosphere is friendly and accepting and the training interactive, making it enjoyable and interesting.

Some of the things you will learn include:

- How to help your foster child open up to you
- Therapeutic limit setting
- Recognizing emotional needs and building self-esteem
- Fostering creativity, self-control, and self-responsibility

Free Classes begin soon! Call Carolyn Carlisle Hacker (865.310.4225) to Enroll		
Date:	Time:	Location:

Modified brochure for the CPRT Model of Filial Therapy (Landreth and Bratton, 2006)

APPENDIX C

Foster Parent Control Group Brochure

Foster Parent Focus Group Forming Now!

Being a foster parent is a tough job! A foster parent focus group is a place where foster parents can share their experiences and challenges in a safe, friendly and accepting environment. Issues, ideas, challenges, child advocacy, and public policy will be discussed in this group especially for YOU!

This group will be held for five weeks for approximately one and a half hours per session. The atmosphere will be interactive and informative.

Some of the things you will experience:

- An opportunity to discuss and process the challenges of being a foster parent
- Foster parents just like you, experiencing similar challenges and successes
- A variety of resources available to foster parents and foster children
- A forum for addressing and promoting quality foster care
- An experienced Licensed Professional Counselor will be available to facilitate the group

Free Group begin soon! Call Carolyn Carlisle Hacker (865.471.3271) or email chacker@cn.edu to Enroll. You will receive a $25 stipend and 5 hours training certificate for your participation

Date: Thursday **mornings** 2/5, 2/12, 2/19, 2/26 and 3/5 **or** Thursday **evenings** 2/5, 2/12, 2/19, 2/26 and 3/5	Time: **10:00 – 11:00 am** **6:00 to 7:00 pm**	Location: Kirkwood Club House 7860 Ellisville Lane Knoxville, TN

APPENDIX D
Initial Assessment

Name of foster parent_____

DOB/Age_____

Name of foster child_____

DOB/Age_____

Address

_____

_____

Phone (home)_____ Phone (cell) _____

Foster Parent Information

Has the foster parent participated in mental health counseling/therapy previously? [ ]Yes [ ]No

If yes, did the foster parent view counseling as successful? Why or why not?

_____

_____

_____

_____

_____

_____

Parenting strengths:

_____

_____

_____

_____

_____

_____

Parenting challenges:

Health of the foster parent:

Has the foster parent been prescribed any medications (specify)?

Medication	Prescribing physician	Date Prescribed

Current relationship between the foster parent and foster child

Is the foster child's current placement secure? [ ] Yes [ ] No

Parent's method of discipline;

Is this method of discipline effective? [ ]Yes
[ ]No

Is the foster parent able to read and write on the 6th grade or above grade level? [ ]Yes
[ ]No

Is the foster parent is willing to commit to a thirty minute play session each week with their foster child during the filial therapy intervention? [ ]Yes
[ ]No

What does the foster parent hope to gain from Child Parent Relationship Therapy?

Child Information

Is the child's current foster placement the first placement outside of his or her family of origin?

[ ] Yes [ ] No

If no, how many previous foster placements has the child experienced? _____

Has the foster child participated in mental health counseling or play therapy previously?

[ ]Yes [ ]No

If yes, did the foster parent view the counseling or play therapy as successful? Why or why not?

_____

_____

_____

_____

_____

_____

If yes, how did the child view the counseling or play therapy process?

_____

_____

_____

_____

_____

_____

Child's strengths:

_____

_____

_____

_____

_____

_____

Child's presenting behavioral problems:

_____

_____

_____

_____

_____

_____

Physical health of child:

_____

_____

_____

_____

_____

_____

Is the child currently taking prescribed medication (specify)?

Medication	Prescribing physician	Date Prescribed

Is the child between the ages of three and nine years of age? [ ]Yes
[ ]No

Is the child able to engage in representational play? [ ]Yes
[ ]No

_____

Investigators name (printed) Date

_____

Signature of Investigator Date

APPENDIX E

Randolph Attachment Disorder Questionnaire

RADQ ANSWER SHEET

Completed by: Mother ____ Father ____ Other _____ (list job title of other person)

Child's Name _____ Age _____ Date _____

DIRECTIONS: Read each of the items below and circle the number that **BEST** describes how often your child does that behavior. If he/she usually does it (90% or more of the time), circle the 5. If he/she often does it (75% of the time), circle the 4. If he/she does it about half the time, circle the 3. If it is occasionally present (25% of the time), circle the 2. If it is rarely or never present (less than 10% of the time), circle the 1. DO NOT circle more than one number for each item, and make sure you circle a number for each item. DO NOT mark between the numbers. Please rate your child's behavior over the past 2 years, unless specifically asked not to for research purposes.

(5) usually (4) often (3) sometimes (2) occasionally (1) rarely

1) My child acts overly cute and charms others to get them to do what he/she wants.	5	4	3	2	1
2) My child has trouble making eye contact when adults want him/her to.	5	4	3	2	1
3) My child is overly friendly with strangers.	5	4	3	2	1
4) My child pushes me away or becomes stiff when I try to hug him/her, unless he/she wants something from me.	5	4	3	2	1
5) My child argues for long periods of time, often about ridiculous things.	5	4	3	2	1
6) My child has a tremendous need to have control over everything, becoming very upset if things don't go his/her way.	5	4	3	2	1
7) My child acts amazingly innocent, or pretends that things aren't that bad when he/she is caught doing something wrong.	5	4	3	2	1
8) My child does very dangerous things, ignoring how he/she may be hurt while doing them.	5	4	3	2	1
9) My child deliberately breaks or ruins things.	5	4	3	2	1
10) My child doesn't seem to feel age-appropriate guilt for his/her actions (seems to lack a conscience for his/her actions).	5	4	3	2	1
11) My child teases, hurts, or is cruel to other children.	5	4	3	2	1
12) My child seems unable to stop him/herself from doing things impulsively.	5	4	3	2	1
13) My child steals, or shows up with things that belong to others, with unusual or suspicious reasons for how he/she got them.	5	4	3	2	1
14) My child demands things, instead of asking for them.	5	4	3	2	1

(5) usually	(4) often	(3) sometimes	(2) occasionally	(1) rarely

15) My child doesn't seem to learn from his/her mistakes and misbehavior (no matter what consequence I give, the child continues the behavior).	5	4	3	2	1
16) My child tries to get sympathy from others by telling them that I abuse and/or neglect him/her.	5	4	3	2	1
17) My child "shakes off" pain when he/she is hurt, refusing to let anyone comfort him/her.	5	4	3	2	1
18) My child likes to sneak things without permission, even though he/she could have had them if he/she had asked.	5	4	3	2	1
19) My child is a pathological liar (lies when it would be easier to tell the truth, or lies about obvious or ridiculous things).	5	4	3	2	1
20) My child is very bossy with other children and adults.	5	4	3	2	1
21) My child hoards or sneaks food, or has other unusual eating habits (eats paper, raw flour, package mixes, baker's chocolate, etc.).	5	4	3	2	1
22) My child can't keep friends for more than a week.	5	4	3	2	1
23) My child throws temper tantrums (screaming fits, throws stuff, hits and/or kicks walls) that last for two hours or longer.	5	4	3	2	1
24) My child chatters non-stop, asks repeated questions about things that make no sense, mutters, or has other oddities in his/her speech.	5	4	3	2	1
25) My child is accident-prone (gets hurt a lot), or complains a lot about every little ache and pain (needs constant band-aids).	5	4	3	2	1
26) My child teases, hurts, or is cruel to animals.	5	4	3	2	1
27) My child doesn't do as well in school as he/she could with even a little more effort.	5	4	3	2	1
28) My child has set fires, or is preoccupied with fire.	5	4	3	2	1
29) My child prefers to watch violent cartoons and/or tv shows or horror movies (regardless of whether you let him/her do this).	5	4	3	2	1
30) My child was abused/neglected, had severe chronic pain, had more than one change in caregiver, was separated from his/her mother for more than two days, or was in an orphanage during the first two years of his/her life.	5	4	3	2	1

Appendix F

Therapist Notebook

Child Parent Relationship Therapy (CPRT)

Therapist Notebook

Treatment Outlines and Handouts for Sessions 1-10

Sue C. Bratton • Garry L. Landreth • Theresa Kellam • Sandra R. Blackard

Routledge

Using the Therapist Notebook

The ***Therapist Notebook*** is organized by treatment sessions and contains all materials that the therapist needs to conduct the 10-session CPRT model, including Treatment Outlines for Sessions 1–10 and all corresponding parent handouts, homework, and parent worksheets—with sample answers for the therapist. Sample answers are provided only as an example—there are other responses that could be used that would be consistent with the Child-Centered Play Therapy (CCPT) philosophy. For additional CCPT skills and responses, refer to Chapter 5, "CPRT Skills, Concepts, and Attitudes," in the companion CPRT text (Landreth & Bratton, 2006). The *Therapist Notebook* contains copies of all handouts in the *Parent Notebook*, with a reference to the page number where the handout can be found in the CD-Rom version of the *Parent Notebook*. In preparation for each parent training session, print the Materials Checklist (Appendix A on the accompanying CD-ROM) and review the *Study Guide* for the treatment outline for that session.

It is recommended that the therapist print out the entire *Therapist Notebook* from the CD-ROM prior to beginning treatment. As noted previously, the CD-ROM files also provide the therapist the flexibility to adapt the Treatment Outlines in the *Therapist Notebook* by downloading and adapting the files to accommodate individual training styles and therapist level of experience. For example, the experienced CPRT/filial therapist may prefer a less detailed outline, while the novice CPRT therapist may prefer to add more detailed explanations of concepts or skills. Outlines can also be altered to accommodate co-leaders. We have found that using a three-ring binder with tabs for each session is an efficient method of organizing and using the materials.

These materials are designed to be flexible to help you adapt the training to the developmental needs of parents and children. As noted in the CPRT text (Landreth & Bratton, 2006), the 10-session curriculum presented in this manual can be adapted for use in fewer sessions, as well as extended for a longer number of sessions, depending on parent needs and group size. Although designed for use with groups of parents, the materials are also easily adapted for use with individual parents and couples. As with any treatment/intervention, therapists are expected to exercise clinical judgment in the use of materials and procedures.

Child Parent Relationship Therapy (CPRT)

Session 1 – Treatment Outline

Time Marker

Note: Print material checklist for this session (CD-Rom, Appendix A – contains list of all materials and where to locate them)

____ I. Give Name Tags and *Parent Notebooks* to All Parents as They Arrive

(Ask parents who need to complete intake information to stay afterward.)

Introduce self/welcome group—have parents briefly share about themselves and why they are here; help them feel supported and that they are not alone in their struggles

____ II. Overview of CPRT Training Objectives and Essential Concepts

Rule of Thumb: "Focus on the donut, not the hole!"

CPRT focuses on the relationship, your strengths and your child's strengths, NOT the problem.

- Play is the child's language
- Helps prevent problems because parent becomes aware of child's needs

Rule of Thumb: "Be a thermostat, not a thermometer!"

Learn to RESPOND (reflect) rather than REACT. The child's feelings are not your feelings and needn't escalate with him/her.

When your child's feelings and behaviors escalate, you can learn to respond in a helpful way, rather than simply reacting and allowing your feelings and behaviors to escalate, too. Remember: In-control parents are thermostats; out-of-control parents are thermometers.

- You will learn the same basic play therapy skills that graduate students learn in a semester course

  These skills will:

  - Return control to you as parent and help child develop self-control
  - Provide closer, happier times with your child—more joy and laughter, warm memories

    Ask parents: *"What do you want your child to remember about you/your relationship 20 years from now?"* (What are parents' best memories from childhood?)
  - Give key to your child's inner world—learn how to really understand your child and how to help your child feel that you understand
- Best of all, you only have to practice these new skills and do something different 30 minutes per week!

- Patience is important in learning a new language

"In 10 weeks, you are going to be different, and your relationship with your child will be different."

____ III. Group Introductions (facilitate sharing and connections between parents)

- Describe entire family; help pick child of focus if not identified during intake
- Tell concerns about this child (take notes on *Parent Information Form*)
- Facilitate sharing
- Make generalizing/normalizing comments to other parents
  (Example: "Anyone else feel angry with his or her child this week?")

Rule of Thumb: "What's most important may not be what you do, but what you do after what you did!"

We are certain to make mistakes, but we can recover. It is how we handle our mistakes that makes the difference.

____ IV. Reflective Responding

- Way of following, rather than leading
- Reflect behaviors, thoughts, needs/wishes, and feelings (without asking questions)
- Helps parent understand child and helps child feel understood

"Be With" Attitudes Convey:	Not:
I am here; I hear you	I always agree
I understand	I must make you happy
I care	I will solve your problems

____ V. Optional – Show Video Clips: *Life's First Feelings*

Video clip #1: Discuss

Video clip #2: Discuss reactions (especially difference in mad/sad) as lead-in to *Feelings Response: In-Class Practice Worksbeet* (refer parents to page 3 in the *Parent Notebook*)

____ VI. Complete *Feelings Response: In-Class Practice Worksbeet*

Complete worksheet together with parents, asking them, as a group, to decide on the feeling word that best describes how the child is feeling and next, as a group, decide on a short response.

___ VII. Role-Play

Demonstrate wtih co-leader or ask a parent to tell you about his or her day and simply reflect as the parent talks about it; then pair up parents and have them take turns being the "listener"

____ VIII. Video Demonstration (optional, if time permits)

Show demonstration of play session skills of reflection of feeling and allowing the child to lead

____ IX. Homework Assignments (refer parents to homework section in their notebook)

1) Notice one physical characteristic about your child you haven't seen before.

_____

2) Practice reflective responding—complete *Feelings Response: Homework Worksheet* and bring next week.

3) Bring your favorite, heart-tugging picture of your child of focus.

4) Practice giving a 30-second Burst of Attention. If you are on the telephone, say, "Can you hold for 30 seconds? I'll be right back." Put the phone aside, bend down, and give your child undivided, focused attention for 30 seconds; then say, "I have to finish talking to _____." Stand back up and continue talking with your friend.

____ X. Close With Motivational Poem, Story, or Rule of Thumb (optional)

RULES OF THUMB TO REMEMBER:

1. "**Focus on the donut, not the hole!**" Focus on the relationship, NOT the problem.
2. "**Be a thermostat, not a thermometer.**" Learn to RESPOND (reflect) rather than REACT.
3. "**What's most important may not be what you do, but what you do after what you did!**" We all make mistakes, but we can recover. It is how we handle our mistakes that makes the difference.

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Parent Notes & Homework – Session 1

RULES OF THUMB TO REMEMBER:

1. **"Focus on the donut, not the hole!"** Focus on the Relationship, NOT the Problem.
2. **"Be a thermostat, not a thermometer."** Learn to RESPOND (reflect) rather than REACT.
3. **"What's most important may not be what you do, but what you do after what you did!"** We all make mistakes, but we can recover. It is how we handle our mistakes that makes the difference.

Reflective Responding:

A way of following, rather than leading

Reflect behaviors, thoughts, needs/wishes, and feelings (without asking questions)

Helps parent understand child and helps child feel understood

"Be With" Attitudes Convey:	Not:
I am here; I hear you	I always agree
I understand	I must make you happy
I care	I will solve your problems

Notes (use back for additional notes):

Homework Assignments:

1. Notice one physical characteristic about your child you haven't seen before.

---

2. Practice reflective responding (complete ***Feeling Response: Homework Worksheet*** and bring next week).
3. Bring your favorite, heart-tugging picture of your child of focus.
4. Practice giving a 30-second Burst of Attention. If you are on the telephone, say, "Can you hold for 30 seconds? I'll be right back." Put the phone aside, bend down, and give your child undivided, focused attention for 30 seconds; then say, "I have to finish talking to ___." Stand back up and continue talking with your friend.

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Feelings Response: In-Class Practice Worksheet - Session 1

Directions: 1) Look into child's eyes for clue to feeling. 2) After you've decided what child is feeling, put the feeling word into a short response, generally beginning with you, "you seem sad," or "you're really mad at me right now." 3) Your facial expression & tone of voice should match your child's (empathy is conveyed more through nonverbals than verbals).

Child: Adam is telling you all the things he's going to show Grandma and Grandpa when they get to your house.

Child Felt: *Excited, Happy, Glad*

Parent Response: *You're excited that Grandma & Grandpa are coming.*

Child: Sally gets in the car after school and tells you that Bert, the class pet hamster, died—and then tells you about how she was in charge of feeding Bert last week and how he would look at her and then get on his wheel and run.

Child Felt: *Sad, Disappointed*

Parent Response: *You're sad that Bert died.*

Child: Andy was playing with his friend, Harry, when Harry grabbed Andy's fire truck and wouldn't give it back. Andy tried to get it back and the ladder broke off. Andy comes to you crying and tells you what happened and that it's all Harry's fault.

Child Felt: *Mad, Angry, Upset*

Parent Response: *You're really mad at Harry.*

Child: Sarah was playing in the garage while you were cleaning it out, when a big box of books falls off the shelf and hits the floor behind her. She jumps up and runs over to you.

Child Felt: *Scared, Surprised* (depends on child's facial expression)

Parent Response: *1) That (scared, surprised ...) you!*

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Feelings Response: Homework Worksheet - Session 1

Directions: 1) Look into child's eyes for clue to feeling. 2) After you've decided what child is feeling, put the feeling word into a short response, generally beginning with <u>you</u>, "you seem sad," or "you're really mad at me right now." 3) Remember the importance of your facial expression & tone of voice matching child's (empathy is conveyed more through nonverbals than verbals).

Child: *(what happened / what child did or said)*

_____
_____
_____

Child Felt: _____

Parent Response: _____
_____
_____

Corrected Response: _____
_____
_____

Child: *(what happened / what child did or said)*

_____
_____
_____

Child Felt: _____

Parent Response: _____
_____
_____

Corrected Response: _____
_____
_____

Child: *(what happened / what child did or said)*

_____
_____
_____

Child Felt: _____

Parent Response: _____
_____
_____

Corrected Response: _____
_____
_____

Child: *(what happened / what child did or said)*

_____
_____
_____

Child Felt: _____

Parent Response: _____
_____
_____

Corrected Response: _____
_____
_____

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
What Is It and How Can It Help?

What Is It?

Child-Parent-Relationship (C-P-R) Training is a special 10-session parent training program to help strengthen the relationship between a parent and a child by using 30-minute playtimes once a week. Play is important to children because it is the most natural way children communicate. Toys are like words for children and play is their language. Adults talk about their experiences, thoughts, and feelings. Children use toys to explore their experiences and express what they think and how they feel. Therefore, parents are taught to have special structured 30-minute playtimes with their child using a kit of carefully selected toys in their own home. Parents learn how to respond empathically to their child's feelings, build their child's self-esteem, help their child learn self-control and self-responsibility, and set therapeutic limits during these special playtimes.

For 30 minutes each week, the child is the center of the parent's universe. In this special playtime, the parent creates an accepting relationship in which a child feels completely safe to express himself through his play—fears, likes, dislikes, wishes, anger, loneliness, joy, or feelings of failure. This is not a typical playtime. It is a special playtime in which the child leads and the parent follows. In this special relationship, there are no:

+ reprimands
+ put-downs
+ evaluations
+ requirements (to draw pictures a certain way, etc.)
+ judgments (about the child or his play as being good or bad, right or wrong)

How Can It Help My Child?

In the special playtimes, you will build a different kind of relationship with your child, and your child will discover that she is capable, important, understood, and accepted as she is. When children experience a play relationship in which they feel accepted, understood, and cared for, they play out many of their problems and, in the process, release tensions, feelings, and burdens. Your child will then feel better about herself and will be able to discover her own strengths and assume greater self-responsibility as she takes charge of play situations.

How your child feels about herself will make a significant difference in her behavior. In the special playtimes where you learn to focus on your child rather than your child's problem, your child will begin to react differently because how your child behaves, how she thinks, and how she performs in school are directly related to how she feels about herself. When your child feels better about herself, she will behave in more self-enhancing ways rather than self-defeating ways.

Child Parent Relationship Therapy (CPRT)

Session 2 – Treatment Outline

Time Marker

Note: Print material checklist for this session (CD-Rom, Appendix A – contains list of all materials and where to locate them)

____ **I. Informal Sharing and Review of Homework**

Ask about each parent's week and reflect briefly

Review homework from Session 1:

1. 30-second Burst of Attention
2. *Feelings Response: Homework Worksheet*—refer parents to worksheet for reflecting feelings review and practice

   Remember to reflect parent's experience/model encouragement as parents share
3. Physical characteristic/favorite picture

   Ask questions and reflect answers; ask parents to report a physical characteristic of their child that they hadn't noticed before

____ **II. Handout:** *Basic Principles of Play Sessions* (refer parents to page 9 in the *Parent Notebook*)

1. Parent allows child to lead and parent follows, without asking questions or making suggestions
   - Show keen interest and closely observe
   - **Rule of Thumb: "The parent's toes should follow his/her nose."** Body language conveys interest and full attention
   - Actively join in when invited
   - Parent is "dumb" for 30 minutes
2. The parent's major task is to empathize with the child
   - See and experience the child's play through the child's eyes
   - Understand child's needs, feelings, and thoughts expressed through play
3. Parent is then to communicate this understanding to the child
   - Describing what the child is doing/playing
   - Reflecting what the child is saying
   - Reflecting what the child is feeling

4. The parent is to be clear and firm about the few "limits" that are placed on the child's behavior
   - Gives child responsibility for behavior
   - Limits set on time, for safety, and to prevent breaking toys or damaging play area
   - Stated only when needed, but consistently
5. Note: If time allows, briefly review goals of play sessions on handout

____ III. Demonstration of Toys for Play Session Toy Kit

- Briefly review Toy Categories on *Toy Checklist for Play Sessions* (refer parents to page 10 in the *Parent Notebook*; don't read entire list)
- Demonstrate/show toys and briefly explain rationale—especially for toys that may concern parents (dart gun and baby bottle)
- As toys are shown, briefly provide examples of how you might respond to child playing with that toy (co-leader can role-play with you)
- Discuss finding used, free, and inexpensive toys
- Emphasize the importance of the toys and get commitment that each parent will have over half of the toys by next week—preferably all; if they don't, they likely won't be ready for their first play session
- Discuss pros and cons of involving child in collecting toys for play session kit

____ IV. Choosing a Place and Time for Play Sessions

- Suggest a room that parent believes will offer the fewest distractions to the child and greatest freedom from worry about breaking things or making a mess
  Kitchen area is ideal if no one else at home; otherwise, need to be able to close a door
- Set aside a regular time in advance
  - This time is to be undisturbed—no phone calls or interruptions by other children
  - Most importantly, choose a time when the parent feels most relaxed, rested, and emotionally available to child

Rule of Thumb: "You can't give away that which you don't possess."

(Analogy: oxygen mask on airplane: take care of yourself first, then your child)

You can't extend patience and acceptance to your child if you can't first offer it to yourself. As your child's most significant caregiver, you are asked to give so much of yourself, often when you simply don't have the resources within you to meet the demands of parenting. As parents, you may be deeply aware of your own failures, yet you can't extend patience and acceptance to your child while being impatient and un-accepting of yourself.

- Note: Let parents know that you will be asking each of them to report next week on the place and time they have chosen

_____ V. Role-Play and Demonstration of Basic Play Session Skills (video clip or live)

Make sure to allow at least 15–20 minutes of demonstration, stopping to answer questions and get reactions, and another 5–10 minutes for paired parent role-plays, followed by 5–10 minutes for therapist to role-play "scenarios" parents had difficulty with in their role-play with parent partners

1. Show video clip that clearly demonstrates the concept of setting the stage, allowing the child to lead (without asking questions), tracking, and conveying the "Be With" Attitudes (or conduct live demo focusing on same attitudes and skills)
    - Review the "BE WITH" ATTITUDES: I'm here, I hear you, I understand, and I care!
2. Use filial toy kit or toys in playroom for parents to take turns role-playing child and parent in play session, practicing the skills just demonstrated

_____ VI. Homework Assignments (refer parents to homework section in their notebook)

1) Priority—Collect toys on *Toy Checklist for Play Sessions.*
Brainstorm ideas and sources and suggest parents share resources

2) Select a consistent time and an uninterrupted place in the home suitable for the play sessions and report back next week—whatever room you feel offers the fewest distractions to the child and the greatest freedom from worry about breaking things or making a mess. Set aside a regular time in advance. This time is to be undisturbed—no phone calls or interruptions by other children.
Time _____ Place _____

3) Additional Assignment:

_____ VII. Close With Motivational Poem, Story, or Rule of Thumb (optional)

End session with a motivational book, poem, or story, such as "I'll Love You Forever"

RULES OF THUMB TO REMEMBER:

1. **"The parent's toes should follow his/her nose."**
2. **"You can't give away that which you don't possess."** You can't extend patience and acceptance to your child if you can't first offer it to yourself. As your child's most significant caregiver, you are asked to give so much of yourself, often when you simply don't have the resources within you to meet the demands of parenting. As parents, you may be deeply aware of your own failures, yet you can't extend patience and acceptance to your child while being impatient and un-accepting of yourself.

Remember the analogy of the oxygen mask on an airplane!

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Parent Notes & Homework – Session 2

RULES OF THUMB TO REMEMBER:

1. "The parent's toes should follow his/her nose."
2. **"You can't give away that which you don't possess."** You can't extend patience and acceptance to your child if you can't first offer it to yourself. As your child's most significant caregiver, you are asked to give so much of yourself, often when you simply don't have the resources within you to meet the demands of parenting. As parents, you may be deeply aware of your own failures, yet you can't extend patience and acceptance to your child while being impatient and unaccepting of yourself.

Remember the analogy of the oxygen mask on an airplane!

Remember the "BE WITH" ATTITUDES: I'm here, I hear you, I understand, and I care!

Notes (use back for additional notes):

Homework Assignments:

1. Priority—Collect toys on *Toy Checklist for Play Sessions.*
2. Select a consistent time and an uninterrupted place in the home suitable for the play sessions and report back next week—whatever room you feel offers the fewest distractions to the child and the greatest freedom from worry about breaking things or making a mess. Set aside a regular time in advance. This time is to be undisturbed—no phone calls or interruptions by other children.

Time _____ Place _____

3. Additional assignment:

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Basic Principles of Play Sessions – Session 2

Basic Principles for Play Sessions:

1. The parent sets the stage by structuring an atmosphere in which the **child feels free** to determine how he will use the time during the 30-minute play session. The **child leads** the play and the **parent follows**. The parent follows the child's lead by showing keen interest and carefully observing the child's play, **without making suggestions or asking questions**, and by actively joining in the play when invited by the child. *For 30 minutes, you (parent) are "dumb" and don't have the answers; it is up to your child to make his own decisions and find his own solutions.*
2. The parent's major task is to empathize with the child: to understand the child's thoughts, feelings, and intent expressed in play by working hard to **see and experience the child's play through the child's eyes**. *This task is operationalized by conveying the "Be With" Attitudes below.*
3. The parent is then to **communicate this understanding to the child** by: a) verbally describing what the child is doing/playing, b) verbally reflecting what the child is saying, and c) most importantly, by verbally reflecting the feelings that the child is actively experiencing through his play.
4. The parent is to be clear and firm about the few "limits" that are placed on the child's behavior. Limits are stated in a way that give the child responsibility for his actions and behaviors—helping to foster self-control. Limits to be set are: time limits, not breaking toys or damaging items in the play area, and not physically hurting self or parent. **Limits are to be stated only when needed**, but applied consistently across sessions. *(Specific examples of when and how to set limits will be taught over the next several weeks; you will also have lots of opportunities to practice this very important skill.)*

"Be With" Attitudes:
Your intent in your actions, presence, and responses is what is most important and should convey to your child:
"I am here—I hear/see you—I understand—I care."

Goals of the Play Sessions:

1. To allow the child—through the medium of play—to communicate thoughts, needs, and feelings to his parent, and for the parent to communicate that understanding back to the child.
2. Through feeling accepted, understood, and valued—for the child to experience more positive feelings of self-respect, self-worth, confidence, and competence—and ultimately develop self-control, responsibility for actions, and learn to get needs met in appropriate ways.
3. To strengthen the parent-child relationship and foster a sense of trust, security, and closeness for both parent and child.
4. To increase the level of playfulness and enjoyment between parent and child.

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Toy Checklist for Play Sessions – Session 2

Note: Obtain sturdy cardboard box with sturdy lid to store toys in (box that copier paper comes in is ideal–the deep lid becomes a dollhouse). Use an old quilt or blanket to spread toys out on and to serve as a boundary for the play area.

Real-Life Toys (also promote imaginative play)

- ☐ Small baby doll: *should not be anything "special"; can be extra one that child does not play with anymore*
- ☐ Nursing bottle: *real one so it can be used by the child to put a drink in during the session*
- ☐ Doctor kit (with stethoscope): *add three Band-Aids for each session (add disposable gloves/Ace bandage, if you have)*
- ☐ Toy phones: *recommend getting two in order to communicate: one cell, one regular*
- ☐ Small dollhouse: *use deep lid of box the toys are stored in–draw room divisions, windows, doors, and so forth inside of lid*
- ☐ Doll family: *bendable mother, father, brother, sister, baby, and so forth (ethnically representative)*
- ☐ Play money: *bills and coins; credit card is optional*
- ☐ Couple of domestic and wild animals: *if you don't have doll family, can substitute an animal family (e.g., horse, cow family)*
- ☐ Car/Truck: *one to two small ones (could make specific to child's needs, e.g., an ambulance)*
- ☐ Kitchen dishes: *couple of plastic dishes, cups, and eating utensils*

Optional

- ☐ Puppets: *one aggressive, one gentle; can be homemade or purchased (animal shaped cooking mittens, etc.)*
- ☐ Doll furniture: *for a bedroom, bathroom, and kitchen*
- ☐ Dress up: *hand mirror, bandana, scarf; small items you already have around the house*

Acting-Out Aggressive Toys (also promote imaginative play)

- ☐ Dart guns with a couple of darts and a target: *parent needs to know how to operate*
- ☐ Rubber knife: *small, bendable, army type*
- ☐ Rope: *prefer soft rope (can cut the ends off jump rope)*
- ☐ Aggressive animal: *(e.g., snake, shark, lion, dinosaurs—strongly suggest hollow shark!)*
- ☐ Small toy soldiers (12–15): *two different colors to specify two teams or good guys/bad guys*
- ☐ Inflatable bop bag (Bobo clown style preferable)
- ☐ Mask: *Lone Ranger type*

Optional

- ☐ Toy handcuffs with a key

Toys for Creative/Emotional Expression

- ☐ Playdough: *suggest a cookie sheet to put playdough on to contain mess—also serves as a flat surface for drawing*
- ☐ Crayons: *eight colors, break some and peel paper off (markers are optional for older children but messier)*
- ☐ Plain paper: *provide a few pieces of new paper for each session*
- ☐ Scissors: *not pointed, but cut well (e.g., child Fiskars®)*
- ☐ Transparent tape: *remember, child can use up all of this, so buy several of smaller size*
- ☐ Egg carton, styrofoam cup/bowl: *for destroying, breaking, or coloring*
- ☐ Ring toss game
- ☐ Deck of playing cards
- ☐ Soft foam ball
- ☐ Two balloons per play session

Optional

- ☐ Selection of arts/crafts materials in a ziplock bag *(e.g., colored construction paper, glue, yarn, buttons, beads, scraps of fabrics, raw noodles, etc —much of this depends on age of child)*
- ☐ Tinkertoys®/small assortment of building blocks
- ☐ Binoculars
- ☐ Tambourine, drum, or other small musical instrument
- ☐ Magic wand

Reminder: *Toys need not be new or expensive. Avoid selecting more toys than will fit in a box—toys should be small. In some cases, additional toys can be added based on child's need and with therapist approval. If unable to get every toy before first play session, obtain several from each category—ask therapist for help in prioritizing.*

Note: Unwrap any new toys or take out of box before play session. Toys should look inviting.

Good Toy Hunting Places: garage sales, attic, friends/relatives, "dollar" stores, toy aisles of grocery and drug stores

Child Parent Relationship Therapy (CPRT)

Session 3 – Treatment Outline

Time Marker

Note: Print material checklist for this session (CD-Rom, Appendix A – contains list of all materials and where to locate them)

____ **I. Informal Sharing and Review of Homework**

1. Toys collected
2. Time and place for play sessions

   Very important to ask very specific questions about when and where

   Hand out appointment cards—one for parent and one for child to keep
3. Any questions

____ **II. Handout:** *Play Session Do's & Don'ts* (refer parents to page 13 in the *Parent Notebook*)

- Ask parents to refer to *Play Session Do's & Don'ts* handout as you refer to poster and provide examples
- Demonstrate **Play Session Do's** physically with toys as you go over each one (or role-play with co-leader)

Do:

1. **Do set the stage (structuring).**
2. **Do let the child lead.**
3. **Do join in the child's play actively, as a follower.**
4. Do verbally track child's play (describe what you see).
5. Do reflect the child's feelings.
6. **Do set firm and consistent limits.**
7. Do salute the child's power and encourage effort.
8. Do be verbally active.

Note: Emphasize the bolded **Do's** for parents to focus on in first play session

Don't:

1. Don't criticize any behavior.
2. Don't praise the child.

3. Don't ask leading questions.
4. Don't allow interruptions of the session.
5. Don't give information or teach.
6. Don't preach.
7. Don't initiate new activities.
8. Don't be passive or quiet.

(Don'ts 1–7 are taken from Guerney, 1972)

_____ **III. View Demonstration Video Clip or Do a Live Demonstration Illustrating the Do's**

Video clip should primarily focus on demonstrating the "Be With" Attitudes and the skill of "allowing the child to lead"

_____ **IV. Handout:** *Play Session Procedures Checklist* (refer parents to page 14 in the *Parent Notebook*)

Briefly go over handout—especially what to do before the session to structure for success. Ask parents to read over carefully at least two days before their play session

Refer parents to photograph in their handouts of toys set up for play session

_____ **V. Parent Partners Role-Play**—focusing on skills they saw you demonstrate, as well as practice beginning and ending the session.

_____ **VI. Discuss With Parents How to Explain the "Special Playtime" to Their Child**

Example explanation: "You may wish to explain to your child that you are having these special playtimes with her because 'I am going to this special play class to learn some special ways to play with you!'"

_____ **VII. Arrange for One to Two Parent(s) to Do Videotaping This Week**

Name/phone number _____ day/time (if taping at clinic)_____
Name/phone number _____ day/time (if taping at clinic)_____

Remind parent(s) who are videotaping this week to make note on their Parent Notes & Homework handout

- **Rule of Thumb: "Be a thermostat, not a thermometer."**

  Learn to RESPOND (reflect) rather than REACT. The child's feelings <u>are not</u> your feelings and needn't escalate with him/her.

Reflecting/responding to child's thoughts, feelings, and needs creates a comfortable atmosphere of understanding and acceptance for child.

During the 30-minute play session, parents are asked to be a thermostat for their child.

____ **VIII. Homework Assignments** (refer parents to homework section in their notebook)

1) Complete play session toy kit—get blanket/tablecloth and other materials (see *Photograph of Toys Set Up for Play Session* in handouts) and confirm that the time and place you chose will work. Make arrangements for other children.

2) Give child appointment card and make "Special Playtime—Do Not Disturb" sign with child one to three days ahead (depending on child's age). See *Template for Do Not Disturb Sign* in handouts.

   The younger the child, the closer to time of play session.

3) Read handouts prior to play session:

   Play Session Do's & Don'ts

   Play Session Procedures Checklist

4) Play sessions begin at home this week—arrange to videotape your session and make notes about problems or questions you have about your sessions.

____ *I will bring my videotape for next week (if videotaping at clinic: my appt. day/time _____).*

____ **IX. Close With Motivational Poem, Story, or Rule of Thumb (optional)**

RULE OF THUMB TO REMEMBER:

"Be a thermostat, not a thermometer."

Reflecting/responding to your child's thoughts, feelings, and needs creates a comfortable atmosphere of understanding and acceptance for your child.

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Parent Notes & Homework – Session 3

RULE OF THUMB TO REMEMBER:

"Be a thermostat, not a thermometer."
Reflecting/responding to your child's thoughts, feelings, and needs
creates a comfortable atmosphere of understanding and acceptance for your child.

Basic Limit Setting:

"Sarah, I know you'd like to shoot the gun at me, but I'm not for shooting. You can choose to shoot at that" (point at something acceptable).

Notes (use back for additional notes):

Note: You may wish to explain to your child that you are having these special playtimes with him or her because "I am going to this special play class to learn some special ways to play with you!"

Homework Assignments:

1. Complete play session toy kit—get blanket/quilt and other materials. (see *Photograph of Toys Set Up for Play Session* in handouts) and confirm that the time and place you chose will work. Make arrangements for other children.
2. Give child appointment card and make "Special Playtime—Do Not Disturb" sign with child one to three days ahead (depending on child's age). See Template for Do Not Disturb Sign in handouts.
3. Read over handouts prior to play session:
   Play Session Do's & Don'ts
   Play Session Procedures Checklist
4. Play sessions begin at home this week—arrange to videotape your session and make notes about problems or questions you have about your sessions.

____ *I will bring my videotape for next week (if videotaping at clinic: my appt. day/time ____).*

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Play Session Do's & Don'ts – Session 3

Parents: Your major task is to keenly show interest in your child's play and to communicate your interest in, and understanding of, your child's thoughts, feelings, and behavior through your words, actions, and undivided focus on your child.

Do:

1. **Do set the stage.**
   a. Prepare play area ahead of time (old blanket can be used to establish a visual boundary of the play area, as well as provide protection for flooring; a cookie sheet under the arts/crafts materials provides a hard surface for playdough, drawing, and gluing, and provides ease of clean up).
   b. Display the toys in a consistent manner around the perimeter of the play area.
   c. Convey freedom of the special playtime through your words: *"During our special playtime, you can play with the toys in lots of the ways you'd like to."*
   d. Allow your child to lead by returning responsibility to your child by responding, *"That's up to you," "You can decide," or "That can be whatever you want it to be."*
2. **Do let the child lead.**
   Allowing the child to lead during the playtime helps you to better understand your child's world and what your child needs from you. Convey your willingness to follow your child's lead through your responses: *"Show me what you want me to do," "You want me to put that on," "Hmmm...," or "I wonder...."* Use whisper technique (co-conspirators) when child wants you to play a role: *"What should I say?" or "What happens next?"* (Modify responses for older kids: use conspiratorial tone, "What happens now?" "What kind of teacher am I?" etc.)
3. **Do join in the child's play actively, as a follower.**
   Convey your willingness to follow your child's lead through your responses and your actions, by actively joining in the play (child is the director, parent is the actor): "So I'm supposed to be the teacher," *"You want me to be the robber, and I'm supposed to wear the black mask," "Now I'm supposed to pretend I'm locked up in jail, until you say I can get out," or "You want me to stack these just as high as yours."* Use whisper technique in role-play: "What should I say?" "What happens next?"
4. **Do verbally track the child's play** (describe what you see).
   Verbally tracking your child's play is a way of letting your child know that you are paying close attention and that you are interested and involved: *"You're filling that all the way to the top," "You've decided you want to paint next," or "You've got 'em all lined up just how you want them."*
5. **Do reflect the child's feelings.**
   Verbally reflecting children's feelings helps them feel understood and communicates your acceptance of their feelings and needs: *"You're proud of your picture," "That kind'a surprised you," "You really like how that feels on your hands," "You really wish that we could play longer," "You don't like the way that turned out," or "You sound disappointed." (Hint: Look closely at your child's face to better identify how your child is feeling.)*
6. **Do set firm and consistent limits.**
   Consistent limits create a structure for a safe and predictable environment for children. Children should never be permitted to hurt themselves or you. Limit setting provides an opportunity for your child to develop self-control and self-responsibility. Using a calm, patient, yet firm voice, say, *"The floor's not for putting playdough on; you can play with it on the tray" or "I know you'd like to shoot the gun at me, but I'm not for shooting. You can choose to shoot at that" (point to something acceptable).*
7. **Do salute the child's power and encourage effort.**
   Verbally recognizing and encouraging your child's effort builds self-esteem and confidence and promotes self-motivation: *"You worked hard on that!" "You did it!" "You figured it out!" "You've got a plan for how you're gonna set those up," "You know just how you want that to be," or "Sounds like you know lots about how to take care of babies."*
8. **Do be verbally active.**
   Being verbally active communicates to your child that you are interested and involved in her play. If you are silent, your child will feel watched.
   Note: Empathic grunts—"Hmm..." and so forth—also convey interest and involvement, when you are unsure of how to respond.

Don't:

1. Don't criticize any behavior.
2. Don't praise the child.
3. Don't ask leading questions.
4. Don't allow interruptions of the session.
5. Don't give information or teach.
6. Don't preach.
7. Don't initiate new activities.
8. Don't be passive or quiet.

(Don'ts 1–7 are taken from Guerney, 1972)

Remember the "Be With" Attitudes: Your intent in your responses is what is most important. Convey to your child:

"I am here—I hear/see you—I understand—I care."

Reminder: These play session skills (the new skills you are applying) are relatively meaningless if applied mechanically and not as an attempt to be genuinely empathic and truly understanding of your child. **Your Intent & Attitude Are More Important Than Your Words!**

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Play Session Procedures Checklist - Session 3

Depending on age of child, may need to remind him or her: "Today is the day for our special playtime!"

A. Prior to Session (Remember to "Set the Stage")

- ☐ Make arrangements for other family members (so that there will be no interruptions).
- ☐ Set up toys on old quilt—keep toy placement predictable.
- ☐ Have a clock visible in the room (or wear a watch).
- ☐ Put pets outside or in another room.
- ☐ Let the child use the bathroom prior to the play session.
- ☐ Switch on video recorder.

B. Beginning the Session

- ☐ Child and Parent: Hang "Do Not Disturb" sign (can also "unplug" phone if there is one in play session area). *Message to child: "This is so important that No One is allowed to interrupt this time together."*
- ☐ Tell Child: *"We will have 30 minutes of special playtime, and you can play with the toys in lots of the ways you want to."* (Voice needs to convey that parent is looking forward to this time with child.)
- ☐ From this point, let the child lead.

C. During the Session

- ☐ Sit on the same level as child, close enough to show interest but allowing enough space for child to move freely.
- ☐ Focus your eyes, ears, and body fully on child. (Toes Follow Nose!) Conveys full attention!
- ☐ Your voice should mostly be gentle and caring, but vary with the intensity and affect of child's play.
- ☐ Allow the child to identify the toys. [To promote make-believe play (i.e., what looks like a car to you might be a spaceship to your child), try to use nonspecific words ("this," "that," "it") if child hasn't named toy.]
- ☐ Play actively with the child, if the child requests your participation.
- ☐ Verbally reflect what you see and hear (child's play/activity, thoughts, feelings).
- ☐ Set limits on behaviors that make you feel uncomfortable.
- ☐ Give five-minute advance notice for session's end and then a one-minute notice. (***"Billy, we have five minutes left in our special playtime."***)

D. Ending the Session

- ☐ At 30 minutes, stand and announce, **"Our playtime is over for today."** Do not exceed time limit by more than two to three minutes.
- ☐ Parent does the cleaning up. If child chooses, child may help. (If child continues to play while "cleaning," set limit below.)
- ☐ If child has difficulty leaving:
  - Open the door or begin to put away toys.
  - Reflect child's feelings about not wanting to leave, but calmly and firmly restate that the playtime is over. (Restate limit as many times as needed—the goal is for child to be able to stop herself.) ***"I know you would like to stay and play with the toys, but our special playtime is over for today."***
  - Adding a statement that gives child something to look forward to helps child see that, although she cannot continue to play with the special toys, there is something else she can do that is also enjoyable. For example:
    1. **"You can play with the toys next week during our special playtime."**
    2. **"It's time for snack; would you like grapes or cherries today?"**
    3. **"We can go outside and play on the trampoline."**

Note: Patience is the order of the day when helping child to leave—OK to repeat limit calmly several times to allow child to struggle with leaving on her own. (Key is showing empathy and understanding in your voice tone and facial expressions as you state the limit). Younger children may need more time to 'hear' limit and respond.

Never use Special Playtime for a reward or consequence—NO matter the child's behavior that day!

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Photograph of Toys Set Up for Play Session – Session 3

Child Parent Relationship Therapy (CPRT)

Session 4 – Treatment Outline

Note: Print material checklist for this session (CD-Rom, Appendix A – contains list of all materials and where to locate them)

Rule of Thumb:

When a child is drowning, don't try to teach her to swim.

When a child is feeling upset or out of control, that is not the moment to impart a rule or teach a lesson.

Time Marker

____ **I.** **Informal Sharing, followed by Parent Sharing Highlights of Preparing for and Conducting Home Play Sessions** (parents with video go last)

Be aware of time—keep group process moving!

- Look for something positive to reflect for each parent
- Model encouragement by prizing parents' efforts
- Use parents' sharing to emphasize examples of **Play Session Do's**
  Refer to poster or handout and encourage parents' efforts to recognize the **Play Session Do's**
- Seize opportunities to forge connections between parents with similar struggles

____ **II.** **Videotaped Play Session Review and Supervision**

- Comment primarily on the positive, taking a few words the parent said or non-verbal behavior and turning that into a **Play Session Do** or another teaching point

  Focus on parent's strengths (remember, the Donut Analogy applies to parents, too)

  - Encourage the parent who videotaped the session to share what it was like to be videotaped knowing that she would have to share it with the class
  - Play videotape until a strength is evident
  - Focus on importance of parent's awareness of self in the play session
  - Ask if the parent has a question about some part of the session or if there is some part he/she would particularly like to show—play that portion of the videotape

- Identify only one thing the parent might do differently

- Continue to refer to *Play Session Do's & Don'ts* poster or handout, asking parents to try and identify the **Do's** they see demonstrated in videotapped play session

_____ **III.** **Handout:** *Limit Setting: A-C-T Before It's Too Late* (refer parents to page 19 in the *Parent Notebook*)

(optional) Show video clip on limit setting

- Briefly review the A-C-T model—go over importance of consistency
- Parent is in charge of the structure for the play session: selecting the time and place, establishing necessary limits, and enforcing the limits
- Child is responsible for choices and decisions, within the limits set by parent during playtimes
- Briefly give a few examples of possible limits to set during play sessions

Rule of Thumb: "During play sessions, limits are not needed until they are needed!"

- Review *Limit Setting: A-C-T Practice Worksheet* (refer parents to page 20 & 21 in the *Parent Notebook*)

  Read over and do at least two or three examples together—discuss the rest next week as completed homework; point out question #7, where parents are asked to write down a limit they think they will need to set for their child

- Be prepared for discussion regarding parent concerns about guns (used in limit-setting example)

_____ **IV.** **Role-Play/Video Clip or Live Demonstration of Play Session Skills and Limit Setting**

- Always allow time for parents to see a demonstration of play session skills that you want them to emulate, focusing on those skills they report the most difficulty with
- After viewing demonstration, ask parents to role-play a few scenarios they believe are most difficult for them, including at least one limit-setting role-play

_____ **V.** **Arrange for One to Two Parents to Do Videotaping This Week**

Name/phone number _____day/time (if taping at clinic)_____

Name/phone number _____ day/time (if taping at clinic)_____

Remind parent(s) who are videotaping this week to make note on their Parent Notes & Homework handout

____ **VI. Homework Assignments** (refer parents to homework section in their notebook)

1) Complete *Limit Setting: A-C-T Practice Worksheet.*

2) Read over handouts prior to play session:
Limit Setting: A-C-T Before It's Too Late!
Play Session Dos & Don'ts (from Session 3)
Play Session Procedures Checklist (from Session 3)

3) Conduct play session and complete *Parent Play Session Notes.*

Notice one intense feeling in yourself during your play session this week.

____ *I will bring my videotape for next week (if videotaping at clinic: my appt. day/time _____).*

____ **VII. Close With Motivational Poem, Story, or Rule of Thumb (optional)**

RULES OF THUMB TO REMEMBER:

1. "**When a child is drowning, don't try to teach her to swim.**" When a child is feeling upset or out of control, that is not the moment to impart a rule or teach a lesson.

2. "**During play sessions, limits are not needed until they are needed!**"

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Parent Notes & Homework – Session 4

RULES OF THUMB TO REMEMBER:

1. "When a child is drowning, don't try to teach her to swim." When a child is feeling upset or out of control, that is not the moment to impart a rule or teach a lesson.
2. "During play sessions, limits are not needed until they are needed!"

Basic Limit Setting:

Start by saying child's name: "*Sarah,*"
Reflect feeling: "*I know you'd like to shoot the gun at me…*"
Set limit: "*but I'm not for shooting.*"
Give acceptable alternative: "*You can choose to shoot at that*" (*point at something acceptable*).

Notes (use back for additional notes):

Homework Assignments:

1. Complete *Limit Setting: A-C-T Practice Worksheet.*
2. Read over handouts prior to play session:
   Limit Setting: A-C-T Before It's Too Late!
   Play Session Do's & Don'ts
   Play Session Procedures Checklist
3. Conduct play session and complete *Parent Play Session Notes.*
   Notice one intense feeling in yourself during your play session this week.

   _____ I will bring my videotape for next week (if videotaping at clinic: my appt. day/time _____).

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Limit Setting: A-C-T Before It's Too Late! - Session 4

Acknowledge the feeling
Communicate the limit
Target alternatives

Three Step A-C-T Method of Limit Setting:

Scenario: Billy has been pretending that the bop bag is a bad guy and shooting him with the dart gun; he looks over at you and aims the dart gun at you, then laughs and says, "Now, you're one of the bad guys, too!"

1. Acknowledge your child's feeling or desire (*your voice must convey empathy and understanding*).
   "Billy, I know that you think that it would be fun to shoot me, too…"
   Child learns that his feelings, desires, and wishes are valid and accepted by parent (but not all behavior); just empathically reflecting your child's feeling often defuses the intensity of the feeling or need.
2. Communicate the limit (be specific and clear—and brief).
   "but I'm not for shooting."
3. Target acceptable alternatives (provide one or more choices, depending on age of child).
   "You can pretend that the doll is me (pointing at the doll) and shoot at it."
   The goal is to provide your child with an acceptable outlet for expressing the feeling or the original action, while giving him an opportunity to exercise self-control. Note: Pointing helps redirect child's attention.

When to Set Limits?

- **RULE OF THUMB: "During play sessions, limits are not needed until they are needed!"**

Limits are set only when the need arises, and for four basic reasons:

- To protect child from hurting himself or parent
- To protect valuable property
- To maintain parent's acceptance of child
- To provide consistency in the play session by limiting child and toys to play area and ending on time

Before setting a limit in a play session, ask yourself:

- "Is this limit necessary?"
- "Can I consistently enforce this limit?"
- "If I don't' set a limit on this behavior, can I consistently allow this behavior and accept my child?"

Avoid conducting play sessions in areas of the house that require too many limits. Limits set during play sessions should allow for greater freedom of expression than would normally be allowed. The fewer the limits, the easier it is for you to be consistent—**consistency is very important.** Determine a few limits ahead of time (practice A-C-T): no hitting or shooting at parent; no playdough on carpet; no purposefully breaking toys, and so forth. *Hint: Children really do understand that playtimes are "special" and that the rules are different—they will not expect the same level of permissiveness during the rest of the week.*

How to Set Limits?

Limits are not punitive and should be stated firmly, but calmly and matter-of-factly. After empathically acknowledging your child's feeling or desire (very important step), you state, "The playdough is not for throwing at the table," just like you would state, "The sky is blue." Don't try to force your child to obey the limit. Remember to provide an acceptable alternative. In this method, it really is up to the child to decide to accept or break the limit; however, **it is your job, as the parent, to consistently enforce the limit.**

Why Establish Consistent Limits?

Providing children with consistent limits helps them feel safe and secure. This method of limiting children's behavior teaches them self-control and responsibility for their own behavior by allowing them to experience the consequences of their choices and decisions. Limits set in play sessions help children practice self-control and begin to learn to stop themselves in the real world.

CONSISTENT LIMITS → PREDICTABLE, SAFE ENVIRONMENT → SENSE OF SECURITY

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Limit Setting: A-C-T Practice Worksheet - Session 4

Acknowledge the feeling
Communicate the limit
Target alternatives

EXAMPLE # 1

Billy has been playing like the bop bag is the bad guy and hitting him; he picks up the scissors, looks at you, and then laughs and says, "I'm going to stab him because he's bad!"

A **"Billy, I know that you think that it would be fun to stab the bop bag (bobo)..."**

C **"But the bop bag (bobo) isn't for poking with the scissors."**

T **"You can use the rubber knife"**

EXAMPLE # 2

The play session time is up and you have stated the limit two times. Your child becomes angry because you won't give in and let him play longer; he begins to hit you. Hitting is not allowed, so go immediately to second step of A-C-T, then follow with all three steps of A-C-T method of limit setting.

C (firmly) **"Billy, I'm not for hitting."**

A (empathically) **"I know you're mad at me..."**

C (firmly) **"But people aren't for hitting."**

T (neutral tone) **"You can pretend the bop bag is me and hit it (pointing at bop bag)."**

PRACTICE:

1. Your child begins to color on the dollhouse, saying, "It needs some red curtains!"

(assuming you bought a dollhouse; however, it would be okay to color on a cardboard dollhouse)

A I know you really want to *put curtains on the dollhouse*.

C But the dollhouse *is not for coloring on*.

T You can *make red curtains on the paper and tape them on the dollhouse*.

2. Your child aims a loaded dart gun at you.

A *[Child's name], I know you'd like to shoot the gun at me*.

C *But I'm not for shooting*.

T *You can choose to shoot at that (point at something acceptable)*.

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Page 2—Limit Setting: A-C-T Practice Worksheet - Session 4

3. After 15 minutes of the play session, your child announces that she wants to leave and go outside to play with her friends.

A *I know you would like to go play with your friends right now* .

C *but, we have 15 minutes more in our special playtime* .

T *Then you can go outside and play* .

4. Your child wants to play doctor and asks you to be the patient. Your child asks you to pull up your shirt so that she/he can listen to your heart.

A *[Child's name], I know you want me to pull up my shirt like at a real doctor's office* .

C *But my shirt is not for pulling up* .

T *You can listen to my heart through my shirt (or you can pretend the doll is me and pull up its shirt)* .

5. Describe a situation in which you think you might need to set a limit during the play session.
Situation: _____
_____

A _____ .

C _____ .

T _____ .

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Parent Play Session Notes - Session 4

Play Session #_____ Date: _____

Significant Happenings:

What I Learned About My Child:

Feelings Expressed:

Play Themes:

What I Learned About Myself:

My feelings during the play session:

What I think I was best at:

What was hardest or most challenging for me:

Questions or Concerns:

Skill I Want to Focus on in the Next Play Session: _____

Child Parent Relationship Therapy (CPRT)

Session 5 – Treatment Outline

Time Marker

Note: Print material checklist for this session (CD-Rom, Appendix A – contains list of all materials and where to locate them)

____ I. Informal Sharing, followed by Review of Homework as Parents Report on Play Sessions (Videotaped parents share last)

- Parents share an intense feeling they were aware of during their play sessions

  Focus on importance of self-awareness of parents' feelings in the play session; model by reflecting parents' feelings

- Parents share limit-setting attempts during play sessions

  Remember to focus only on play session happenings—redirect limit-setting questions about outside of play sessions to end of session

  Let parents know you will be reviewing limit-setting homework later in the session after videotape review

- Focus on **Play Session Do's** (use poster for parents to refer to)

  Use examples from parents' comments to reinforce **Do's**—Point out difficult situations and spontaneously role-play with parents on how to respond

- Remember the Donut Analogy: Focus on Strengths and Positive Examples

  Find something in each parent's sharing that can be encouraged and supported—facilitate "connecting" among group members; help them see they are not alone in their parenting difficulties

____ II. Videotaped Play Session Review and Supervision

- View one to two parent-child play sessions, following same procedure as last week
- Model encouragement and facilitate peer feedback
- Refer parents to handout, *In-Class Play Session Skills Checklist,* page 26 in the *Parent Notebook* and ask parents to check off skills they see being demonstrated as therapist or other parents point them out
- Continue to refer to *Play Session Do's & Don'ts* poster/handout (from Session 3)
  - Encourage the parent who videotaped to share a bit about the play session before starting video.

- Play videotape until a strength is evident
- Focus on importance of parent's awareness of self in the play session
- Play portion of videotape that parent has a question about or would particularly like to show
- Ask what the parent thinks he/she does well
- Ask what area the parent would like to work on in his/her next play session

____ III. Limit-Setting Review

(Optional) Show video clip on limit setting

- Review A-C-T Method

  Limit Setting: A-C-T Before It's Too Late! (refer parents to page 19 in the *Parent Notebook*)

  Emphasize importance of using all three steps

  Ask for questions

  Emphasize the importance of stating clear and concise limits

- Review principles of limit setting on *Limit Setting: A-C-T Before It's Too Late!* (refer parents to page 19 in the *Parent Notebook*)
- Review homework worksheet: *Limit Setting: A-C-T Practice Worksheet* (refer parents to page 20 & 21 in the *Parent Notebook*)

  Go over any scenarios not covered in Session 4

  Discuss limits parents might need to set and help with ones they generated

  Ask for questions

- Review handout: *Limit Setting: Why Use the Three-Step A-C-T Method?* (refer parents to page 25 in the *Parent Notebook*) if not enough time, ask parents to readover at home

____ IV. Role-Play/Video Clip or Live Demonstration of Play Session Skills and Limit Setting

- Always allow time for parents to see a demonstration of play session skills that you want them to emulate, focusing on those skills they report the most difficulty with
- After viewing demonstration, ask parents to role-play a few scenarios they believe are most difficult for them, including at least one limit-setting role-play

____ V. Arrange for One to Two Parents to Do Videotaping This Week

Name/phone number _____ day/time (if taping at clinic)_____

Name/phone number _____ day/time (if taping at clinic)_____

Remind parent(s) who are videotaping this week to make note on their Parent Notes & Homework handout

____ VI. Homework Assignments (refer parents to homework section in their notebook)

1) Give each of your children a Sandwich Hug and Sandwich Kiss.

2) Read over handouts prior to play session:

Limit Setting: A-C-T Before It's Too Late! (from Session 4)

Play Session Dos & Don'ts (from Session 3)

Play Session Procedures Checklist (from Session 3)

3) Conduct play session (same time & place):

a. Complete *Parent Play Session Notes*.

b. Use *Play Session Skills Checklist* to note what you thought you did well, and select one skill you want to work on in your next play session.

c. If you needed to set a limit during your playtime, describe on the checklist what happened and what you said or did.

____ I will bring my videotape for next week (if videotaping at clinic: my appt. day/time _____).

4) Additional Assignment:

____ VII. Close With Rule of Thumb

RULE OF THUMB TO REMEMBER:

"If you can't say it in 10 words or less, don't say it."

As parents, we have a tendency to overexplain to our children, and our message gets lost in the words.

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Parent Notes & Homework – Session 5

RULE OF THUMB TO REMEMBER:

"If you can't say it in 10 words or less, don't say it."
As parents, we have a tendency to overexplain to our children, and our message gets lost in the words.

Notes (use back for additional notes):

Homework Assignments:

1. Give each of your children a Sandwich Hug and Sandwich Kiss.
2. Read over handouts prior to play session:
   Limit Setting: A-C-T Before It's Too Late!
   Play Session Dos & Don'ts
   Play Session Procedures Checklist
3. Conduct play session (same time & place).
   a. Complete *Parent Play Session Notes*.
   b. Use *Play Session Skills Checklist* to note what you thought you did well, and select one skill you want to work on in your next play session.
   c. If you needed to set a limit during your playtime, describe on the checklist what happened and what you said or did.

   ___ I will bring my videotape for next week (if videotaping at clinic: my appt. day/time___).
4. Additional assignment:

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Limit Setting: Why Use the Three-Step A-C-T Method - Session 5

Acknowledge the feeling

Communicate the limit

Target alternatives

Discuss the different messages that are implied in the following typical parent responses to unacceptable behavior:

- It's probably not a good idea to paint the wall.
  Message: I'm really not sure whether or not it's okay to paint the wall. It might be okay or it might not.

- You can't paint the walls in here.
  Message: You might be able to paint the walls in the other room.

- I can't let you paint the wall.
  Message: What you do is my responsibility and not your responsibility.

- Maybe you could paint something else other than the wall.
  Message: Maybe you can paint the furniture.

- The rule is you can't paint the wall.
  Message: How you feel about it doesn't matter.

- The wall is not for painting on.
  Message: You're not bad for wanting to, it's just not for anyone to paint on.

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
In-Class Play Session Skills Checklist:
For Review of Videotaped (or Live) Play Session – Session 5

Directions: Indicate ✓ in blank when you observe a play session skill demonstrated in videotaped or live play session

1. ___ Set the Stage/Structured Play Session

2. ___ Conveyed "Be With" Attitudes
   Full attention/interested
   Toes followed nose

3. ___ Allowed Child to Lead
   Avoided giving suggestions
   Avoided asking questions
   Returned responsibility to child

4. ___ Followed Child's Lead
   Physically on child's level
   Moved closer when child was involved in play
   Joined in play when invited—took imaginary/pretend role when appropriate

5. ___ Reflective Responding Skills:

   ___ Reflected child's nonverbal play behavior (Tracking)

   ___ Reflected child's verbalizations (Content)

   ___ Reflected child's feelings/wants/wishes

   ___ Voice tone matched child's intensity/affect

   ___ Responses were brief and interactive

   ___ Facial expressions matched child's affect

6. ___ Used Encouragement/Self-Esteem-Building Responses

7. ___ Set Limits, As Needed, Using A-C-T

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Parent Play Session Notes – Session 5

Play Session #_____ Date: _____

Significant Happenings:

What I Learned About My Child:

Feelings Expressed:

Play Themes:

What I Learned About Myself:

My feelings during the play session:

What I think I was best at:

What was hardest or most challenging for me:

Questions or Concerns:

Skill I Want to Focus on in the Next Play Session: _____

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Play Session Skills Checklist - Session 5

Play Session #_____ Date: _____

(Note: Indicate ✓ in column if skill was used; — if skill was not used; and + if skill was a strength)

✓ — +	Skill	Notes/Comments
	Set the Stage/Structured Play Session	
	Conveyed "Be With" Attitudes *Full attention/interested* *Toes followed nose*	
	Allowed Child to Lead *Avoided giving suggestions* *Avoided asking questions* *Returned responsibility to child*	
	Followed Child's Lead *Physically on child's level* *Moved closer when child was involved in play* *Joined in play when invited*	
	Reflective Responding Skills:	
	Reflected child's nonverbal play (Tracking)	
	Reflected child's verbalizations (Content)	
	Reflected child's feelings/wants/wishes	
	Voice tone matched child's intensity/affect	
	Responses were brief and interactive	
	Facial expressions matched child's affect	
	Use of Encouragement/Self-Esteem-Building Responses	
	Set Limits, As Needed, Using A-C-T	

Child Parent Relationship Therapy (CPRT)

Session 6 – Treatment Outline

Time Marker

Note: Print material checklist for this session (CD-Rom, Appendix A – contains list of all materials and where to locate them)

____ **I. Informal Sharing, followed by Review of Homework as Parents Report on Play Sessions (Videotaped parents share last)**

- Parents share experience giving each of their children a Sandwich Hug and Sandwich Kiss
- Parents share limit-setting attempts during play sessions. Review A-C-T Limit Setting as needed (refer to handout from Session 4, page 19 in the parent notebook)

  Remember to focus only on play session happenings—redirect other questions about limit setting by letting parents know you will be focusing on limit setting more later in the session
- Continue debriefing play sessions, focusing on parents' perceived changes in their own behavior (Videotaped parents or last)

  Focus on **Play Session Do's** (use poster for parents to refer to)

  Use examples from parents' comments to reinforce **Do's**

  Point out difficult situations and spontaneously role-play with parents on how to respond
- Remember the Donut Analogy: Focus on the Positive! Find something in each parent's sharing that can be encouraged and supported—facilitate "connecting" among group members.

____ **II. Videotaped Play Session Review and Supervision**

- View one to two parent-child play sessions, following same procedure as last week
- Model encouragement and facilitate peer feedback
- Refer parents to handout, *In-Class Play Session Skills Checklist,* page 35 in the *Parent Notebook* and ask parents to check off skills they see being demonstrated
- Continue to refer to *Play Session Do's & Don'ts* poster/handout

  Remind parents that, for children,

  parental consistency > predictability > security > child feeling safe and loved!

APPENDIX G

Parent Notebook

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING

PARENT NOTEBOOK

Parent Handouts,
Notes, and Homework
Sessions 1-10

Sue C. Bratton • Garry L. Landreth • Theresa Kellam • Sandra R. Blackard

Routledge
Taylor & Francis Group

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Parent Notes & Homework – Session 1

RULES OF THUMB TO REMEMBER:

1. **"Focus on the donut, not the hole!"** Focus on the Relationship, NOT the Problem.
2. **"Be a thermostat, not a thermometer."** Learn to RESPOND (reflect) rather than REACT.
3. **"What's most important may not be what you do, but what you do after what you did!"**
   We all make mistakes, but we can recover. It is how we handle our mistakes that makes the difference.

Reflective Responding:

A way of following, rather than leading

Reflect behaviors, thoughts, needs/wishes, and feelings (without asking questions)

Helps parent understand child and helps child feel understood

"Be With" Attitudes Convey:	Not:
I am here; I hear you	I always agree
I understand	I must make you happy
I care	I will solve your problems

Notes (use back for additional notes):

Homework Assignments:

1. Notice one physical characteristic about your child you haven't seen before.

---

2. Practice reflective responding (complete ***Feeling Response: Homework Worksheet*** and bring next week).
3. Bring your favorite, heart-tugging picture of your child of focus.
4. Practice giving a 30-second Burst of Attention. If you are on the telephone, say, "Can you hold for 30 seconds? I'll be right back." Put the phone aside, bend down, and give your child undivided, focused attention for 30 seconds; then say, "I have to finish talking to ____." Stand back up and continue talking with your friend.

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Additional Parents Notes – Session 1

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Feelings Response: In-Class Practice Worksheet – Session 1

Directions: 1) Look into child's eyes for clue to feeling. 2) After you've decided what child is feeling, put the feeling word into a short response, generally beginning with <u>you</u>, "you seem sad," or "you're really mad at me right now." 3) Your facial expression & tone of voice should match your child's (empathy is conveyed more through nonverbals than verbals).

Child: Adam is telling you all the things he's going to show Grandma and Grandpa when they get to your house.

Child Felt: _____

Parent Response: _____

Child: Sally gets in the car after school and tells you that Bert, the class pet hamster, died—and then tells you about how she was in charge of feeding Bert last week and how he would look at her and then get on his wheel and run.

Child Felt: _____

Parent Response: _____

_____

Child: Andy was playing with his friend, Harry, when Harry grabbed Andy's fire truck and wouldn't give it back. Andy tried to get it back and the ladder broke off. Andy comes to you crying and tells you what happened and that it's all Harry's fault.

Child Felt: _____

Parent Response: _____

Child: Sarah was playing in the garage while you were cleaning it out, when a big box of books falls off the shelf and hits the floor behind her. She jumps up and runs over to you.

Child Felt: _____

Parent Response: _____

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Feelings Response: Homework Worksheet – Session 1

Directions: 1) Look into child's eyes for clue to feeling. 2) After you've decided what child is feeling, put the feeling word into a short response, generally beginning with <u>you</u>, "you seem sad," or "you're really mad at me right now." 3) Remember the importance of your facial expression & tone of voice matching child's (empathy is conveyed more through nonverbals than verbals).

Child: *(what happened / what child did or said)*

Child Felt: _____

Parent Response: _____

Corrected Response: _____

Child: *(what happened / what child did or said)*

Child Felt: _____

Parent Response: _____

Corrected Response: _____

Child: *(what happened / what child did or said)*

Child Felt: _____

Parent Response: _____

Corrected Response: _____

Child: *(what happened / what child did or said)*

Child Felt: _____

Parent Response: _____

Corrected Response: _____

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
What Is It and How Can It Help?

What Is It?

Child-Parent-Relationship (C-P-R) Training is a special 10-session parent training program to help strengthen the relationship between a parent and a child by using 30-minute playtimes once a week. Play is important to children because it is the most natural way children communicate. Toys are like words for children and play is their language. Adults talk about their experiences, thoughts, and feelings. Children use toys to explore their experiences and express what they think and how they feel. Therefore, parents are taught to have special structured 30-minute playtimes with their child using a kit of carefully selected toys in their own home. Parents learn how to respond empathically to their child's feelings, build their child's self-esteem, help their child learn self-control and self-responsibility, and set therapeutic limits during these special playtimes.

For 30 minutes each week, the child is the center of the parent's universe. In this special playtime, the parent creates an accepting relationship in which a child feels completely safe to express himself through his play—fears, likes, dislikes, wishes, anger, loneliness, joy, or feelings of failure. This is not a typical playtime. It is a special playtime in which the child leads and the parent follows. In this special relationship, there are no:

+ Reprimands
+ Put-downs
+ Evaluations
+ Requirements (to draw pictures a certain way, etc.)
+ Judgments (about the child or his play as being good or bad, right or wrong)

How Can It Help My Child?

In the special playtimes, you will build a different kind of relationship with your child, and your child will discover that she is capable, important, understood, and accepted as she is. When children experience a play relationship in which they feel accepted, understood, and cared for, they play out many of their problems and, in the process, release tensions, feelings, and burdens. Your child will then feel better about herself and will be able to discover her own strengths and assume greater self-responsibility as she takes charge of play situations.

How your child feels about herself will make a significant difference in her behavior. In the special playtimes where you learn to focus on your child rather than your child's problem, your child will begin to react differently because how your child behaves, how she thinks, and how she performs in school are directly related to how she feels about herself. When your child feels better about herself, she will behave in more self-enhancing ways rather than self-defeating ways.

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Parent Notes & Homework – Session 2

RULES OF THUMB TO REMEMBER:

1. **"The parent's toes should follow his/her nose."**
2. **"You can't give away that which you don't possess."** You can't extend patience and acceptance to your child if you can't first offer it to yourself. As your child's most significant caregiver, you are asked to give so much of yourself, often when you simply don't have the resources within you to meet the demands of parenting. As parents, you may be deeply aware of your own failures, yet you can't extend patience and acceptance to your child while being impatient and un-accepting of yourself.

Remember the analogy of the oxygen mask on an airplane!

Remember the "BE WITH" ATTITUDES: I'm here, I hear you, I understand, and I care!

Notes (use back for additional notes):

Homework Assignments:

1. Priority—Collect toys on *Toy Checklist for Play Sessions*.
2. Select a consistent time and an uninterrupted place in the home suitable for the play sessions and report back next week—whatever room you feel offers the fewest distractions to the child and the greatest freedom from worry about breaking things or making a mess. Set aside a regular time in advance. This time is to be undisturbed—no phone calls or interruptions by other children.

Time _____ Place _____

3. Additional assignment:

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Additional Parents Notes – Session 2

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Basic Principles of Play Sessions – Session 2

Basic Principles for Play Sessions:

1. The parent sets the stage by structuring an atmosphere in which the **child feels free** to determine how he will use the time during the 30-minute play session. The **child leads** the play and the **parent follows**. The parent follows the child's lead by showing keen interest and carefully observing the child's play, **without making suggestions or asking questions**, and by actively joining in the play when invited by the child. *For 30 minutes, you (parent) are "dumb" and don't have the answers; it is up to your child to make his own decisions and find his own solutions.*
2. The parent's major task is to empathize with the child: to understand the child's thoughts, feelings, and intent expressed in play by working hard to **see and experience the child's play through the child's eyes**. *This task is operationalized by conveying the "Be With" Attitudes below.*
3. The parent is then to **communicate this understanding to the child** by: a) verbally describing what the child is doing/playing, b) verbally reflecting what the child is saying, and c) most importantly, by verbally reflecting the feelings that the child is actively experiencing through his play.
4. The parent is to be clear and firm about the few "limits" that are placed on the child's behavior. Limits are stated in a way that give the child responsibility for his actions and behaviors—helping to foster self-control. Limits to be set are: time limits, not breaking toys or damaging items in the play area, and not physically hurting self or parent. **Limits are to be stated only when needed**, but applied consistently across sessions. *(Specific examples of when and how to set limits will be taught over the next several weeks; you will also have lots of opportunities to practice this very important skill.)*

"Be With" Attitudes:
Your intent in your actions, presence, and responses is what is most important and should convey to your child:
"I am here—I hear/see you—I understand—I care."

Goals of the Play Sessions:

1. To allow the child—through the medium of play—to communicate thoughts, needs, and feelings to his parent, and for the parent to communicate that understanding back to the child.
2. Through feeling accepted, understood, and valued—for the child to experience more positive feelings of self-respect, self-worth, confidence, and competence—and ultimately develop self-control, responsibility for actions, and learn to get needs met in appropriate ways.
3. To strengthen the parent-child relationship and foster a sense of trust, security, and closeness for both parent and child.
4. To increase the level of playfulness and enjoyment between parent and child.

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Toy Checklist for Play Sessions – Session 2

Note: Obtain sturdy cardboard box with sturdy lid to store toys in (box that copier paper comes in is ideal–the deep lid becomes a dollhouse). Use an old quilt or blanket to spread toys out on and to serve as a boundary for the play area.

Real-Life Toys (also promote imaginative play)

- ☐ Small baby doll: *should not be anything "special"; can be extra one that child does not play with anymore*
- ☐ Nursing bottle: *real one so it can be used by the child to put a drink in during the session*
- ☐ Doctor kit (with stethoscope): *add three Band-Aids for each session (add disposable gloves/Ace bandage, if you have)*
- ☐ Toy phones: *recommend getting two in order to communicate: one cell, one regular*
- ☐ Small dollhouse: *use deep lid of box the toys are stored in–draw room divisions, windows, doors, and so forth inside of lid*
- ☐ Doll family: *bendable mother, father, brother, sister, baby, and so forth (ethnically representative)*
- ☐ Play money: *bills and coins; credit card is optional*
- ☐ Couple of domestic and wild animals: *if you don't have doll family, can substitute an animal family (e.g., horse, cow family)*
- ☐ Car/Truck: *one to two small ones (could make specific to child's needs, e.g., an ambulance)*
- ☐ Kitchen dishes: *couple of plastic dishes, cups, and eating utensils*

Optional

- ☐ Puppets: *one aggressive, one gentle; can be homemade or purchased (animal shaped cooking mittens, etc.)*
- ☐ Doll furniture: *for a bedroom, bathroom, and kitchen*
- ☐ Dress up: *hand mirror, bandana, scarf; small items you already have around the house*

Acting-Out Aggressive Toys (also promote imaginative play)

- ☐ Dart guns with a couple of darts and a target: *parent needs to know how to operate*
- ☐ Rubber knife: *small, bendable, army type*
- ☐ Rope: *prefer soft rope (can cut the ends off jump rope)*
- ☐ Aggressive animal: *(e.g., snake, shark, lion, dinosaurs—strongly suggest hollow shark!)*
- ☐ Small toy soldiers (12–15): *two different colors to specify two teams or good guys/bad guys*
- ☐ Inflatable bop bag (Bobo *clown style preferable)*
- ☐ Mask: *Lone Ranger type*

Optional

- ☐ Toy handcuffs with a key

Toys for Creative/Emotional Expression

- ☐ Playdough: *suggest a cookie sheet to put playdough on to contain mess—also serves as a flat surface for drawing*
- ☐ Crayons: *eight colors, break some and peel paper off (markers are optional for older children but messier)*
- ☐ Plain paper: *provide a few pieces of new paper for each session*
- ☐ Scissors: *not pointed, but cut well (e.g., child Fiskars®)*
- ☐ Transparent tape: *remember, child can use up all of this, so buy several of smaller size*
- ☐ Egg carton, styrofoam cup/bowl: *for destroying, breaking, or coloring*
- ☐ Ring toss game
- ☐ Deck of playing cards
- ☐ Soft foam ball
- ☐ Two balloons per play session

Optional

- ☐ Selection of arts/crafts materials in a ziplock bag *(e.g., colored construction paper, glue, yarn, buttons, beads, scraps of fabrics, raw noodles, etc —much of this depends on age of child)*
- ☐ Tinkertoys®/small assortment of building blocks
- ☐ Binoculars
- ☐ Tambourine, drum, or other small musical instrument
- ☐ Magic wand

Reminder: *Toys need not be new or expensive. Avoid selecting more toys than will fit in a box—toys should be small. In some cases, additional toys can be added based on child's need and with therapist approval. If unable to get every toy before first play session, obtain several from each category—ask therapist for help in prioritizing.*

Note: Unwrap any new toys or take out of box before play session. Toys should look inviting.

Good Toy Hunting Places: garage sales, attic, friends/relatives, "dollar" stores, toy aisles of grocery and drug stores

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Parent Notes & Homework – Session 3

RULE OF THUMB TO REMEMBER:

"Be a thermostat, not a thermometer."
Reflecting/responding to your child's thoughts, feelings, and needs
creates a comfortable atmosphere of understanding and acceptance for your child.

Basic Limit Setting:

"Sarah, "I know you'd like to shoot the gun at me, but I'm not for shooting. You can choose to shoot at that" (point at something acceptable).

Notes (use back for additional notes):

Note: You may wish to explain to your child that you are having these special playtimes with him or her because "I am going to this special play class to learn some special ways to play with you!"

Homework Assignments:

1. Complete play session toy kit—get blanket/quilt and other materials. (see *Photograph of Toys Set Up for Play Session* in handouts) and confirm that the time and place you chose will work. Make arrangements for other children.
2. Give child appointment card and make "Special Playtime—Do Not Disturb" sign with child one to three days ahead (depending on child's age). See Template for Do Not Disturb Sign in handouts.
3. Read over handouts prior to play session:
   Play Session Do's & Don'ts
   Play Session Procedures Checklist
4. Play sessions begin at home this week—arrange to videotape your session and make notes about problems or questions you have about your sessions.

____ *I will bring my videotape for next week (if videotaping at clinic: my appt. day/time ____).*

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Additional Parents Notes – Session 3

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Play Session Do's & Don'ts – Session 3

Parents: Your major task is to keenly show interest in your child's play and to communicate your interest in, and understanding of, your child's thoughts, feelings, and behavior through your words, actions, and undivided focus on your child.

Do:

1. **Do set the stage.**
   a. Prepare play area ahead of time (old blanket can be used to establish a visual boundary of the play area, as well as provide protection for flooring; a cookie sheet under the arts/crafts materials provides a hard surface for playdough, drawing, and gluing, and provides ease of clean up).
   b. Display the toys in a consistent manner around the perimeter of the play area.
   c. Convey freedom of the special playtime through your words: "*During our special playtime, you can play with the toys in lots of the ways you'd like to.*"
   d. Allow your child to lead by returning responsibility to your child by responding, "*That's up to you.*" "*You can decide,*" or "*That can be whatever you want it to be.*"
2. **Do let the child lead.**
   Allowing the child to lead during the playtime helps you to better understand your child's world and what your child needs from you. Convey your willingness to follow your child's lead through your responses: "*Show me what you want me to do,*" "*You want me to put that on,*" "Hmmm...," or "I wonder...." Use whisper technique (co-conspirators) when child wants you to play a role: "*What should I say?*" or "*What happens next?*" (Modify responses for older kids: use conspiratorial tone, "What happens now?" "What kind of teacher am I?" etc.)
3. **Do join in the child's play actively, as a follower.**
   Convey your willingness to follow your child's lead through your responses and your actions, by actively joining in the play (child is the director, parent is the actor): "So I'm supposed to be the teacher," "You want me to be the robber, and I'm supposed to wear the black mask," "Now I'm supposed to pretend I'm locked up in jail, until you say I can get out," or "You want me to stack these just as high as yours." Use whisper technique in role-play: "What should I say?" "What happens next?"
4. **Do verbally track the child's play** (describe what you see).
   Verbally tracking your child's play is a way of letting your child know that you are paying close attention and that you are interested and involved: "*You're filling that all the way to the top,*" "*You've decided you want to paint next,*" or "*You've got 'em all lined up just how you want them.*"
5. **Do reflect the child's feelings.**
   Verbally reflecting children's feelings helps them feel understood and communicates your acceptance of their feelings and needs: "*You're proud of your picture,*" "*That kind'a surprised you,*" "*You really like how that feels on your hands,*" "*You really wish that we could play longer,*" "*You don't like the way that turned out,*" or "*You sound disappointed.*" (*Hint: Look closely at your child's face to better identify how your child is feeling.*)
6. **Do set firm and consistent limits.**
   Consistent limits create a structure for a safe and predictable environment for children. Children should never be permitted to hurt themselves or you. Limit setting provides an opportunity for your child to develop self-control and self-responsibility. Using a calm, patient, yet firm voice, say, "*The floor's not for putting playdough on; you can play with it on the tray*" or "*I know you'd like to shoot the gun at me, but I'm not for shooting. You can choose to shoot at that*"(*point to something acceptable*).
7. **Do salute the child's power and encourage effort.**
   Verbally recognizing and encouraging your child's effort builds self-esteem and confidence and promotes self-motivation: "*You worked hard on that!*" "*You did it!*" "*You figured it out!*" "*You've got a plan for how you're gonna set those up,*" "*You know just how you want that to be,*" or "*Sounds like you know lots about how to take care of babies.*"
8. **Do be verbally active.**
   Being verbally active communicates to your child that you are interested and involved in her play. If you are silent, your child will feel watched.
   Note: Empathic grunts—"Hmm..."and so forth—also convey interest and involvement, when you are unsure of how to respond.

Don't:

1. Don't criticize any behavior.
2. Don't praise the child.
3. Don't ask leading questions.
4. Don't allow interruptions of the session.
5. Don't give information or teach.
6. Don't preach.
7. Don't initiate new activities.
8. Don't be passive or quiet.

(Don'ts 1–7 are taken from Guerney, 1972)

Remember the "Be With" Attitudes: Your intent in your responses is what is most important. Convey to your child:
"I am here—I hear/see you—I understand—I care."

Reminder: These play session skills (the new skills you are applying) are relatively meaningless if applied mechanically and not as an attempt to be genuinely empathic and truly understanding of your child. **Your Intent & Attitude Are More Important Than Your Words!**

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Play Session Procedures Checklist – Session 3

Depending on age of child, may need to remind him or her: "Today is the day for our special playtime!"

A. Prior to Session (Remember to "Set the Stage")
- ☐ Make arrangements for other family members (so that there will be no interruptions).
- ☐ Set up toys on old quilt—keep toy placement predictable.
- ☐ Have a clock visible in the room (or wear a watch).
- ☐ Put pets outside or in another room.
- ☐ Let the child use the bathroom prior to the play session.
- ☐ Switch on video recorder.

B. Beginning the Session
- ☐ Child and Parent: Hang "Do Not Disturb" sign (can also "unplug" phone if there is one in play session area). *Message to child: "This is so important that No One is allowed to interrupt this time together."*
- ☐ Tell Child: "*We will have 30 minutes of special playtime, and you can play with the toys in lots of the ways you want to.*"
  (Voice needs to convey that parent is looking forward to this time with child.)
- ☐ From this point, let the child lead.

C. During the Session
- ☐ Sit on the same level as child, close enough to show interest but allowing enough space for child to move freely.
- ☐ Focus your eyes, ears, and body fully on child. (Toes Follow Nose!) Conveys full attention!
- ☐ Your voice should mostly be gentle and caring, but vary with the intensity and affect of child's play.
- ☐ Allow the child to identify the toys. [To promote make-believe play (i.e., what looks like a car to you might be a spaceship to your child), try to use nonspecific words ("this," "that," "it") if child hasn't named toy.]
- ☐ Play actively with the child, if the child requests your participation.
- ☐ Verbally reflect what you see and hear (child's play/activity, thoughts, feelings).
- ☐ Set limits on behaviors that make you feel uncomfortable.
- ☐ Give five-minute advance notice for session's end and then a one-minute notice.
  (*"Billy, we have five minutes left in our special playtime."*)

D. Ending the Session
- ☐ At 30 minutes, stand and announce, "**Our playtime is over for today.**" Do not exceed time limit by more than two to three minutes.
- ☐ Parent does the cleaning up. If child chooses, child may help. (If child continues to play while "cleaning," set limit below.)
- ☐ If child has difficulty leaving:
  - Open the door or begin to put away toys.
  - Reflect child's feelings about not wanting to leave, but calmly and firmly restate that the playtime is over. (Restate limit as many times as needed—the goal is for child to be able to stop herself.)
    "*I know you would like to stay and play with the toys, but our special playtime is over for today.*"
  - Adding a statement that gives child something to look forward to helps child see that, although she cannot continue to play with the special toys, there is something else she can do that is also enjoyable. For example:
    1. "You can play with the toys next week during our special playtime."
    2. "It's time for snack; would you like grapes or cherries today?"
    3. "We can go outside and play on the trampoline."

Note: Patience is the order of the day when helping child to leave—OK to repeat limit calmly several times to allow child to struggle with leaving on her own. (Key is showing empathy and understanding in your voice tone and facial expressions as you state the limit). Younger children may need more time to 'hear' limit and respond.

Never use Special Playtime for a reward or consequence—NO matter the child's behavior that day!

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Photograph of Toys Set Up for Play Session - Session 3

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Parent Notes & Homework – Session 4

RULES OF THUMB TO REMEMBER:

1. "When a child is drowning, don't try to teach her to swim." When a child is feeling upset or out of control, that is not the moment to impart a rule or teach a lesson.
2. "During play sessions, limits are not needed until they are needed!"

Basic Limit Setting:

Start by saying child's name: "*Sarah,*"
Reflect feeling: "*I know you'd like to shoot the gun at me…*"
Set limit: "*but I'm not for shooting.*"
Give acceptable alternative: "*You can choose to shoot at that*" (*point at something acceptable*).

Notes (use back for additional notes):

Homework Assignments:

1. Complete *Limit Setting: A-C-T Practice Worksheet.*
2. Read over handouts prior to play session:
   Limit Setting: A-C-T Before It's Too Late!
   Play Session Do's & Don'ts
   Play Session Procedures Checklist
3. Conduct play session and complete *Parent Play Session Notes.*
   Notice one intense feeling in yourself during your play session this week.

   _____ I will bring my videotape for next week (if videotaping at clinic: my appt. day/time _____).

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Additional Parents Notes - Session 4

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Limit Setting: A-C-T Before It's Too Late! - Session 4

Acknowledge the feeling
Communicate the limit
Target alternatives

Three Step A-C-T Method of Limit Setting:

Scenario: Billy has been pretending that the bop bag is a bad guy and shooting him with the dart gun; he looks over at you and aims the dart gun at you, then laughs and says, "Now, you're one of the bad guys, too!"

1. Acknowledge your child's feeling or desire (*your voice must convey empathy and understanding*).
   "Billy, I know that you think that it would be fun to shoot me, too…"
   Child learns that his feelings, desires, and wishes are valid and accepted by parent (but not all behavior); just empathically reflecting your child's feeling often defuses the intensity of the feeling or need.
2. Communicate the limit (be specific and clear—and brief).
   "But I'm not for shooting."
3. Target acceptable alternatives (provide one or more choices, depending on age of child).
   "You can pretend that the doll is me (pointing at the doll) and shoot at it."
   The goal is to provide your child with an acceptable outlet for expressing the feeling or the original action, while giving him an opportunity to exercise self-control. Note: Pointing helps redirect child's attention.

When to Set Limits?

- **RULE OF THUMB: "During play sessions, limits are not needed until they are needed!"**

Limits are set only when the need arises, and for four basic reasons:

- To protect child from hurting himself or parent
- To protect valuable property
- To maintain parent's acceptance of child
- To provide consistency in the play session by limiting child and toys to play area and ending on time

Before setting a limit in a play session, ask yourself:

- "Is this limit necessary?"
- "Can I consistently enforce this limit?"
- "If I don't' set a limit on this behavior, can I consistently allow this behavior and accept my child?"

Avoid conducting play sessions in areas of the house that require too many limits. Limits set during play sessions should allow for greater freedom of expression than would normally be allowed. The fewer the limits, the easier it is for you to be consistent—**consistency is very important.** Determine a few limits ahead of time (practice A-C-T): no hitting or shooting at parent; no playdough on carpet; no purposefully breaking toys, and so forth. *Hint: Children really do understand that playtimes are "special" and that the rules are different—they will not expect the same level of permissiveness during the rest of the week.*

How to Set Limits?

Limits are not punitive and should be stated firmly, but calmly and matter-of-factly. After empathically acknowledging your child's feeling or desire (very important step), you state, "The playdough is not for throwing at the table," just like you would state, "The sky is blue." Don't try to force your child to obey the limit. Remember to provide an acceptable alternative. In this method, it really is up to the child to decide to accept or break the limit; however, **it is your job, as the parent, to consistently enforce the limit.**

Why Establish Consistent Limits?

Providing children with consistent limits helps them feel safe and secure. This method of limiting children's behavior teaches them self-control and responsibility for their own behavior by allowing them to experience the consequences of their choices and decisions. Limits set in play sessions help children practice self-control and begin to learn to stop themselves in the real world.

CONSISTENT LIMITS → PREDICTABLE, SAFE ENVIRONMENT → SENSE OF SECURITY

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Limit Setting: A-C-T Practice Worksheet - Session 4

Acknowledge the feeling
Communicate the limit
Target alternatives

EXAMPLE # 1

Billy has been playing like the bop bag is the bad guy and hitting him; he picks up the scissors, looks at you, and then laughs and says, "I'm going to stab him, because he's bad!"

A **"Billy, I know that you think that it would be fun to stab the bop bag (bobo)..."**

C **"but the bop bag (bobo) isn't for poking with the scissors."**

T **"You can use the rubber knife."**

EXAMPLE # 2

The play session time is up and you have stated the limit two times. Your child becomes angry because you won't give in and let him play longer; he begins to hit you. Hitting is not allowed, so go immediately to second step of A-C-T, then follow with all three steps of A-C-T method of limit setting.

C (firmly) **"Billy, I'm not for hitting."**

A (empathically) **"I know you're mad at me..."**

C (firmly) **"But people aren't for hitting."**

T (neutral tone) **"You can pretend the bop bag is me and hit it (pointing at bop bag)."**

PRACTICE:

1. Your child begins to color on the dollhouse, saying, "It needs some red curtains!"

   (assuming you bought a dollhouse; however, it would be okay to color on a cardboard box/dollhouse)

A I know you really want to _____.

C But the dollhouse _____.

T You can _____.

2. Your child aims a loaded dart gun at you.

A _____.

C _____.

T _____.

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Page 2—Limit Setting: A-C-T Practice Worksheet - Session 4

3. After 15 minutes of the play session, your child announces that she wants to leave and go outside to play with her friends.

A _____.
C _____.
T _____.

4. Your child wants to play doctor and asks you to be the patient. Your child asks you to pull up your shirt so that she/he can listen to your heart.

A _____.
C _____.
T _____.

5. Describe a situation in which you think you might need to set a limit during the play session.
Situation: _____
_____

A _____.
C _____.
T _____.

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Parent Play Session Notes - Session 4

Play Session #_____ Date: _____

Significant Happenings:

What I Learned About My Child:

Feelings Expressed:

Play Themes:

What I Learned About Myself:

My feelings during the play session:

What I think I was best at:

What was hardest or most challenging for me:

Questions or Concerns:

Skill I Want to Focus on in the Next Play Session: _____

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Parent Notes & Homework – Session 5

RULE OF THUMB TO REMEMBER:

"If you can't say it in 10 words or less, don't say it."
As parents, we have a tendency to overexplain to our children, and our message gets lost in the words.

Notes (use back for additional notes):

Homework Assignments:

1. Give each of your children a Sandwich Hug and Sandwich Kiss.
2. Read over handouts prior to play session:
   Limit Setting: A-C-T Before It's Too Late!
   Play Session Dos & Don'ts
   Play Session Procedures Checklist
3. Conduct play session (same time & place).
   a. Complete *Parent Play Session Notes*.
   b. Use *Play Session Skills Checklist* to note what you thought you did well, and select one skill you want to work on in your next play session.
   a. If you needed to set a limit during your playtime, describe on the checklist what happened and what you said or did.

   ___ I will bring my videotape for next week (if videotaping at clinic: my appt. day/time___).
4. Additional assignment:

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Additional Parents Notes – Session 5

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Limit Setting: Why Use the Three-Step A-C-T Method - Session 5

Acknowledge the feeling

Communicate the limit

Target alternatives

Discuss the different messages that are implied in the following typical parent responses to unacceptable behavior:

- It's probably not a good idea to paint the wall.
  Message: _____
- You can't paint the walls in here.
  Message: _____
- I can't let you paint the wall.
  Message: _____
- Maybe you could paint something else other than the wall.
  Message: _____
- The rule is you can't paint the wall.
  Message: _____
- The wall is not for painting on.
  Message: _____

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
In-Class Play Session Skills Checklist:
For Review of Videotaped (or Live) Play Session – Session 5

Directions: Indicate ✓ in blank when you observe a play session skill demonstrated in videotaped or live play session

1. ___ Set the Stage/Structured Play Session

2. ___ Conveyed "Be With" Attitudes
   Full attention/interested
   Toes followed nose

3. ___ Allowed Child to Lead
   Avoided giving suggestions
   Avoided asking questions
   Returned responsibility to child

4. ___ Followed Child's Lead
   Physically on child's level
   Moved closer when child was involved in play
   Joined in play when invited—took imaginary/pretend role when appropriate

5. ___ Reflective Responding Skills:

   ___ Reflected child's nonverbal play behavior (Tracking)

   ___ Reflected child's verbalizations (Content)

   ___ Reflected child's feelings/wants/wishes

   ___ Voice tone matched child's intensity/affect

   ___ Responses were brief and interactive

   ___ Facial expressions matched child's affect

6. ___ Used Encouragement/Self-Esteem-Building Responses

7. ___ Set Limits, As Needed, Using A-C-T

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Parent Play Session Notes – Session 5

Play Session #_____ Date: _____

Significant Happenings:

What I Learned About My Child:

Feelings Expressed:

Play Themes:

What I Learned About Myself:

My feelings during the play session:

What I think I was best at:

What was hardest or most challenging for me:

Questions or Concerns:

Skill I Want to Focus on in the Next Play Session: _____

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Play Session Skills Checklist - Session 5

Play Session #_____ Date: _____

(Note: Indicate ✓ in column if skill was used; — if skill was not used; and + if skill was a strength)

✓— +	Skill	Notes/Comments
	Set the Stage/Structured Play Session	
	Conveyed "Be With" Attitudes *Full attention/interested* *Toes followed nose*	
	Allowed Child to Lead *Avoided giving suggestions* *Avoided asking questions* *Returned responsibility to child*	
	Followed Child's Lead *Physically on child's level* *Moved closer when child was involved in play* *Joined in play when invited*	
	Reflective Responding Skills:	
	Reflected child's nonverbal play (Tracking)	
	Reflected child's verbalizations (Content)	
	Reflected child's feelings/wants/wishes	
	Voice tone matched child's intensity/affect	
	Responses were brief and interactive	
	Facial expressions matched child's affect	
	Use of Encouragement/Self-Esteem-Building Responses	
	Set Limits, As Needed, Using A-C-T	

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Parent Notes & Homework – Session 6

RULES OF THUMB TO REMEMBER:

1. **"Grant in fantasy what you can't grant in reality."** In a play session, it is okay to act out feelings and wishes that in reality may require limits. For example, it's okay for the "baby sister" doll to be thrown out a window in playtime.
2. **"Big choices for big kids, little choices for little kids."** Choices given must be commensurate with child's developmental stage.

Notes (use back for additional notes):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Homework Assignments:

1. Read *Choice-Giving 101: Teaching Responsibility & Decision-Making* and *Advanced Choice-Giving: Providing Choices as Consequences.*
2. Read *Common Problems in Play Sessions* and mark the top two to three issues you have questions about or write in an issue you are challenged by that is not on the worksheet.
3. Practice giving at least one kind of choice ("A" or "B") outside of the play session.
   A. Provide choices for the sole purpose of empowering your child (two positive choices for child, where either choice is acceptable to you and either choice is desirable to child)
   What happened _____
   What you said _____
   How child responded _____

   B. Practice giving choices as a method of discipline (where choice-giving is used to provide a consequence for noncompliance of limit, family rule, or policy)
   What happened _____
   What you said _____
   How child responded _____
4. Conduct play session (same time & place)—review *Play Session Do's & Don'ts & Play Session Procedure Checklist*
   a. Complete *Parent Play Session Notes.*
   b. Use *Play Session Skills Checklist* to note what you thought you did well, and select one skill you want to work on in your next play session.
   ____ *I will bring my videotape for next week (if videotaping at clinic: my appt. day/time _____).*
5. Additional assignment:

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Additional Parents Notes – Session 6

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING

Choice-Giving 101: Teaching Responsibility & Decision-Making – Session 6

- Providing children with age-appropriate choices empowers children by allowing them a measure of control over their circumstances. Children who feel more empowered and "in control" are more capable of regulating their own behavior, a prerequisite for self-control. Choices require that children tap into their inner resources, rather than relying on parents (external resources) to stop their behavior or solve the problem for them. If parents always intervene, the child learns that "Mom or Dad will stop me if I get out of hand" or "Mom or Dad will figure out a solution if I get in a jam."
- Presenting children with choices provides opportunities for decision-making and problem-solving. Through practice with choice-making, children learn to accept responsibility for their choices and actions and learn they are competent and capable. Choice-giving facilitates the development of the child's conscience; as children are allowed to learn from their mistakes, they learn to weigh decisions based on possible consequences.
- Providing children with choices reduces power struggles between parent and child and, importantly, preserves the child-parent relationship. Both parent and child are empowered; parent is responsible for, or in control of, providing parameters for choices, and the child is responsible for, or in control of, his decision (within parent-determined parameters).

Choice-Giving Strategies

- Provide age-appropriate choices that are equally acceptable to the child and to you. Remember that you must be willing to live with the choice the child makes. Do not use choices to try and manipulate the child to do what you want by presenting one choice that you want the child to choose and a second choice that you know the child won't like.
- Provide little choices to little kids; big choices to big kids. *Example: A 3-year-old can only handle choosing between two shirts or two food items. "Sarah, do you want to wear your red dress or your pink dress to school?" "Sarah, do you want an apple or orange with your lunch?"*

Choice-Giving to Avoid Potential Problem Behavior and Power Struggles

Choices can be used to avoid a potential problem. Similar to the example above, choices given are equally acceptable to parent and child. In this case, choices are planned in advance by the parent to avoid problems that the child has a history of struggling with. In the example above, if Sarah has trouble getting dressed in the morning, provide a choice of what to wear the evening before (to avoid a struggle the next morning); after she has made the choice, take the dress out of the closet, ready for morning. Children who are given the responsibility for making a decision are more likely to abide by the decision.

In selecting choices to prevent problems, it is very important that parents understand the real problem that their child is struggling with. If your child always comes home hungry and wants something sweet, but you want him to have a healthy snack, plan ahead by having on hand at least two choices of healthy snacks that your child likes. Before he heads for the ice cream, say:

"Billy, I bought grapes and cherries for snack; which would you like?"

Or, if you made your child's favorite cookies, and it is acceptable for your 5-year-old to have one or two cookies, say:

"Billy, I made your favorite cookies today; would you like one cookie or two?"

Hint: This is another place where "structuring for success" can be applied by eliminating the majority of unacceptable snack items and stocking up on healthy snack items! Structuring your home environment to minimize conflict allows both you and your child to feel more "in control." Remember: Be a thermostat!

Suggested Reading for Parents: "Teaching Your Child to Choose," Parenting, October, 2002.

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING

Advance Choice-Giving: Providing Choices as Consequences – Session 6-7

Children need parental guidance and discipline. In many instances, parents must make decisions for children—decisions that children are not mature enough to take responsibility for—such as bedtime, other matters of health and safety, and compliance with household policies and rules. However, parents can provide their children with some measure of control in the situation by providing choices.

Oreo® Cookie Method of Choice-Giving (from "Choices, Cookies, & Kids" video by Dr. Garry Landreth)

Example 1: Three-year-old Sarah is clutching a handful of Oreo® cookies, ready to eat them all (it is right before bedtime, and the parent knows it would not be healthy for Sarah to have all the cookies. But Sarah does not know that—she just knows that she wants cookies!): **"Sarah, you can choose to keep one of the cookies to eat and put the rest back, or you can put all of the cookies back—which do you choose?"** Or, if it is permissible to the parent for Sarah to have two cookies: **"Sarah, you can have one cookie or two—which do you choose?"**

Example 2: Three-year-old Sarah does not want to take her medicine and adamantly tells you so! Taking the medicine is not a choice—that is a given. But the parent can provide the child with some control over the situation by saying, **"Sarah, you can choose to have apple juice or orange juice with your medicine—which do you choose?"**

Example 3: Seven-year-old Billy is tired and cranky and refuses to get in the car to go home from Grandma and Grandpa's house. **"Billy, you can choose to sit in the front seat with Daddy, or you can choose to sit in the back seat with Sarah—which do you choose?"**

Choice-Giving to Enforce Household Policies and Rules

Choice-giving can be used to enforce household policies/rules. Begin by working on one at a time. In general, provide two choices—one is phrased positively (consequence for complying with policy), and the other choice (consequence for not complying with policy) is stated as a consequence that you believe your child would not prefer (such as giving up favorite TV show). Consequence for noncompliance should be relevant and logical rather than punitive, and it must be **enforceable**.

Example: A household rule has been established that toys in the family room must be picked up off the floor before dinner (children cannot seem to remember without being told repeatedly, and parent is feeling frustrated with constant reminders and power struggles).

"We are about to institute a new and significant policy within the confines of this domicile" (big words get children's attention!). **"When you choose to pick up your toys before dinner, you choose to watch 30 minutes of television after dinner. When you choose not to pick up your toys before dinner, you choose not to watch television after dinner."** *Note: Be sure to let children know when there are 10–15 minutes before dinner, so they can have time to pick up their toys.*

Children may be able to comply the first time you announce this new policy, because you have just informed them. But what is important is that you begin to allow your children to use their internal resources and self-control to remember the new policy without constant reminders. (Remember that the new policy was implemented because you were frustrated and tired of nagging!) So, the second night, parent says, **"Billy and Sarah, dinner will be ready in 10 minutes; it is time to pick up your toys."** Parent walks out. When it is time for dinner, parent goes back into room to announce dinner:

a) The toys have not been picked up—say nothing at that moment. After dinner, go back into family room and announce to children, **"Looks like you decided to not watch television tonight."** Even if children get busy picking up the toys, they have already chosen not to watch TV for this night. **"Oh, you're thinking that if you pick your toys up now that you can watch TV, but the policy is that toys have to be put away before dinner."** After children plead for another chance, *follow through on the consequence,* calmly and empathically stating: **"I know that you wish you would have chosen to put your toys away before dinner, so you could choose to watch TV now. Tomorrow night, you can choose to put your toys away before dinner and choose to watch TV."** *Some children will choose not to watch TV for several nights in a row!*

b) The children are busy picking up toys and have put most of them away. Parent says (as she helps with the few remaining toys to demonstrate spirit of cooperation and prevent delay of dinner), **"It's time for dinner—looks like you've chosen to watch TV after dinner tonight."**

Guidelines for Choice-Giving in Relation to Limit Setting and Consequences

- Enforce consequence **without fail** and **without anger.**
- Consequence is for "today" only—each day (or play session) should be a chance for a fresh start; a chance to have learned from the previous decision and resulting consequence; a chance to use internal resources to control "self" and make a different decision.
- **Reflect** child's choice with empathy, but remain firm. Consistency and follow-through are critical!
- Communicate choices in a matter-of-fact voice—power struggles are likely to result if child hears frustration or anger in parent's voice and believes parent is invested in one choice over another. Child must be free to choose consequence for noncompliance.

Caution: *Once your child has reached the stage of "out of control," your child may not be able to hear and process a choice. Take a step back and focus on your child's feelings, reflecting her feelings empathically while limiting unacceptable behavior and holding her, if necessary, to prevent her from hurting herself or you.*

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Common Problems in Play Sessions – Session 6

Q: My child notices that I talk differently in the play sessions and wants me to talk normally. What should I do?

A: Say, "I sound different to you. That's my way of letting you know I heard what you said. Remember, I'm going to that special class to learn how to play with you." (The child may be: saying he notices the parent is different; having a surprise reaction to the verbal attention; annoyed by too much reflection of words; or saying he notices the difference in the parent's reflective-type responses. The child may also be saying he doesn't want the parent to change, because that will mean he must then change and adjust to the parent's new way of responding.)

Q: My child asks many questions during the play sessions and resents my not answering them. What should I do?

A: We always begin by reflecting the child's feelings. "You're angry at me." Sometimes a child feels insecure when a parent changes typical ways of responding and is angry because he doesn't know how to react. Your child may feel insecure and be trying to get your attention the way he has done in the past. Your objective is to encourage your child's self-reliance and self-acceptance. "In our special playtime, the answer can be anything you want it to be." For example, your child might ask, "What should I draw?" You want your child to know he's in charge of his drawing during the special playtime, so you respond, "You've decided to draw, and in this special playtime, you can draw whatever you decide." Our objective is to empower the child, to enable the child to discover his own strengths.

Q: My child just plays and has fun. What am I doing wrong?

A: Nothing. Your child is supposed to use the time however she wants. The relationship you are building with your child during the special playtimes is more important than whether or not your child is working on a problem. As your relationship with your child is strengthened, your child's problem will diminish. Your child may be working on issues through her play that you are not aware of. Remember the lesson of the Band-Aid. What you are doing in the playtimes is working, even when you don't see any change. Children can change as a result of what they do in play sessions with parents or play therapists, even though we are not aware of what they are working on. Your job during the special playtimes is to follow your child's lead and be nonjudgmental, understanding, and accepting of your child. Your empathic responses will help your child focus on the issues that are important to her.

Q: I'm bored. What's the value of this?

A: Being bored in a playtime is not an unusual happening because parents have busy schedules, are on the go a lot, and are not used to sitting and interacting quietly for 30 minutes. You can increase your interest level and involvement in your child's play by responding to what you see in your child's face and asking yourself questions such as "What is he feeling?" "What is he trying to say in his play?" "What does he need from me?" or "What is so interesting to him about the toy or the play?" and by making more tracking responses and reflective responses. The most important thing you can do is continue to be patient with the process of the play sessions.

Q: My child doesn't respond to my comments. How do I know I'm on target?

A: Usually when you are on target, your child will let you know. If she doesn't respond to a reflection, you may want to explore other feelings she might be having or convey that you're trying to understand. For example, if you have reflected "You really are angry!" and your child doesn't respond, you might say, "... Or maybe it's not anger you're feeling, maybe you're just feeling really strong and powerful." If your child still doesn't respond, you might say, "Maybe that's not it either. I wonder what it could be that you're feeling."

Q: When is it okay for me to ask questions, and when is it not okay?

A: Most of the time, questions can be rephrased as statements, for example, "I wonder if that's ever happened to you" instead of "Has that ever happened to you?" The only type of questions that are okay in play sessions are spoken as "stage whispers," as in "What should I say?"

Q: My child hates the play sessions. Should I discontinue them?

A: Communicating understanding is always important. Say, "You don't want to have the special play-time. You would rather do something else. Let's have the special playtime for 10 minutes, then you can decide if you want to have the rest of the special playtime or do something else." This response helps your child to feel understood and to feel in control. A child in that position in a relationship is much more likely to compromise. In most cases, a child will get started playing and will decide to have the rest of the playtime.

Q: My child wants the playtime to be longer. Should I extend the session?

A: Even though your child is having lots of fun, the time limit is adhered to because this promotes consistency, affords you an opportunity to be firm, and provides your child with an opportunity to bring himself under control and end a very desirable playtime. Use A-C-T limit setting, being sure to acknowledge your child's feelings. For example, you can say, "You're really having fun and would like to play a lot longer, but our special playtime is over for today. We will have another special playtime next Tuesday." If your child persists, you could say, "Joey, I wish we had more time, too, but our 30 minutes are up for today. We'll get to have another playtime next Tuesday."

Q: My child wants to play with the toys at other times during the week. Is that OK?

A: Allowing your child to play with these toys only during the 30-minute playtimes helps to convey the message that this is a special time, a time just for the two of you, a fun time. Setting the toys apart makes the playtime unique and more desirable. Another reason is that this time with your child is an emotional relationship time; the toys become a part of that emotional relationship during which your child expresses and explores emotional messages through the toys because of the kinds of empathic responses you make. This same kind of emotional exploration cannot occur during other playtimes because you are not there to communicate understanding of your child's play. Additionally, being allowed to play with these toys only during the special playtimes helps your child learn to delay his need for gratification. If you are having trouble keeping your child from playing with the special toy kit, try storing it out of sight on the top shelf of your closet. If that doesn't work, lock it in the trunk of your car.

Q: My child wants me to shoot at him during the play session. What should I do?

A: Set the limit. If your child says, "I'm the bad guy, shoot me," say, "I know you want me to shoot you, but you're not for shooting; I can pretend you're the bad guy getting away, and I'll catch you, or you can draw a picture of the bad guy getting shot."

Q: _____

_____

_____

_____

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
In-Class Play Session Skills Checklist:
For Review of Videotaped (or Live) Play Session – Session 6

Directions: Indicate ✓ in blank when you observe a play session skill demonstrated in videotaped or live play session

1. ___ Set the Stage/Structured Play Session

2. ___ Conveyed "Be With" Attitudes
   Full attention/interested
   Toes followed nose

3. ___ Allowed Child to Lead
   Avoided giving suggestions
   Avoided asking questions
   Returned responsibility to child

4. ___ Followed Child's Lead
   Physically on child's level
   Moved closer when child was involved in play
   Joined in play when invited—took imaginary/pretend role when appropriate

5. ___ Reflective Responding Skills:

   ___ Reflected child's nonverbal play behavior (Tracking)

   ___ Reflected child's verbalizations (Content)

   ___ Reflected child's feelings/wants/wishes

   ___ Voice tone matched child's intensity/affect

   ___ Responses were brief and interactive

   ___ Facial expressions matched child's affect

6. ___ Used Encouragement/Self-Esteem-Building Responses

7. ___ Set Limits, As Needed, Using A-C-T

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Parent Play Session Notes – Session 6

Play Session #_____ Date: _____

Significant Happenings:

What I Learned About My Child:

Feelings Expressed:

Play Themes:

What I Learned About Myself:

My feelings during the play session:

What I think I was best at:

What was hardest or most challenging for me:

Questions or Concerns:

Skill I Want to Focus on in the Next Play Session: _____

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Play Session Skills Checklist - Session 6

Play Session #_____ Date: _____

(Note: Indicate ✓ in column if skill was used; — if skill was not used; and + if skill was a strength)

✓— +	Skill	Notes/Comments
	Set the Stage/Structured Play Session	
	Conveyed "Be With" Attitudes *Full attention/interested* *Toes followed nose*	
	Allowed Child to Lead *Avoided giving suggestions* *Avoided asking questions* *Returned responsibility to child*	
	Followed Child's Lead *Physically on child's level* *Moved closer when child was involved in play* *Joined in play when invited*	
	Reflective Responding Skills:	
	Reflected child's nonverbal play (Tracking)	
	Reflected child's verbalizations (Content)	
	Reflected child's feelings/wants/wishes	
	Voice tone matched child's intensity/affect	
	Responses were brief and interactive	
	Facial expressions matched child's affect	
	Use of Encouragement/Self-Esteem-Building Responses	
	Set Limits, As Needed, Using A-C-T	

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Parent Notes & Homework – Session 7

RULE OF THUMB TO REMEMBER:

"Never do for a child that which he can do for himself."
When you do, you rob your child of the joy of discovery and the opportunity to feel competent. You will never know what your child is capable of unless you allow him to try!

Notes (use back for additional notes):

Homework Assignments:

1. Read *Esteem-Building Responses*—practice giving at least one esteem-building response during your play session (note on *Play Session Skills Checklist*). Also practice giving one esteem-building response outside of your play session.
   What happened outside of play session_____
   What you said _____
   How child responded (verbally or nonverbally)_____
2. Write a note to your child of focus, as well as other children in the family, pointing out a positive character quality you appreciate about the child (see *Positive Character Qualities* handout). Continue to write a note each week for three weeks (mail first note to child, if possible). Write down the following sentence:

   "Dear ____, I was just thinking about you, and what I was thinking is you are so _____ (thoughtful, responsible, considerate, loving, etc.). I love you, _____ (Mom, Dad)."

   Say to the child, in your own words, after the child reads the note (or you read it to the child), "That is such an important quality; we should put that note on the refrigerator (bulletin board, etc.)." Reminder: Don't expect a response from your child.
3. Conduct play session (same time & place)—review *Play Session Do's & Don'ts & Play Session Procedure Checklist*
   a. Complete *Parent Play Session Notes*.
   b. Use *Play Session Skills Checklist* to note what you thought you did well, specifically focus on esteem-building responses, and select one skill you want to work on in your next play session.

____ ***I will bring my videotape for next week (if videotaping at clinic: my appt. day/time _____).***

4. Additional assignment:

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Additional Parents Notes – Session 7

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING

Esteem Building Responses:

Developing Your Child's Sense of Competence - Session 7

Rule of Thumb: "Never do for a child that which he can do for himself."

When you do, you rob your child of the joy of discovery and the opportunity to feel competent. You will never know what your child is capable of unless you allow him to try!

Parents help their child develop a positive view of "self," not only by providing their child with love and unconditional acceptance, but also by helping their child feel competent and capable. Parents help their child feel competent and capable by first allowing the child to **experience** what it is like to discover, figure out, and problem-solve. Parents show faith in their child and their child's capabilities by allowing him to struggle with a problem, all the while providing encouragement (encouragement vs. praise is covered in detail in Session 8). For most parents, allowing children to struggle is hard—but a necessary process for children to truly feel capable. The next step in helping children develop a positive view of self as competent and capable is learning to respond in ways that give children credit for ideas, effort, and accomplishments, without praising.

Esteem-Building Responses to Use in Play Sessions:

"You did it!"
"You figured it out."
"You like the way that turned out."
"You decided…"
"You decided that was the way that was supposed to fit together."
"You know just how you want that to look."
"You're not giving up—you're determined to figure that out."
"You've got a plan for how…"

Example 1: Child works and works to get the lid off the playdough and finally gets it off.
Parent response: **"You did it."**

Example 2: Child works and works to get the lid off the playdough, but can't get it off.
Parent response: **"You're determined to figure that out."**

Example 3: Child struggles to get the dart to fit into the gun and pushed in all the way and finally gets it in.
Parent response: **"You figured it out."**

Example 4: Child spends time drawing, cutting, and gluing a nondescript piece of "art" and shows you with a smile when he is finished.
Parent response: **"You really like the way that turned out."**

Example 5: Child is carefully setting up army soldiers and telling you all about a battle that is going to take place, what is going to happen, and how one side is going to sneak up, and so forth.
Parent response: **"You've got a plan for how that side is…"** or **"You've got that all planned out."**

Note: If your child tends to ask you to do things for him without trying first, ask the therapist to role-play how to return responsibility to your child to do things he is capable of figuring out for himself.

****

The Struggle to Become a Butterfly: A True Story (Author Unknown)

A family in my neighborhood once brought in two cocoons that were just about to hatch. They watched as the first one began to open and the butterfly inside squeezed very slowly and painfully through a tiny hole that it chewed in one end of the cocoon. After lying exhausted for about 10 minutes following its agonizing emergence, the butterfly finally flew out the open window on its beautiful wings.

The family decided to help the second butterfly so that it would not have to go through such an excruciating ordeal. So, as it began to emerge, they carefully sliced open the cocoon with a razor blade, doing the equivalent of a Caesarean section. The second butterfly never did sprout wings, and in about 10 minutes, instead of flying away, it quietly died.

The family asked a biologist friend to explain what had happened. The scientist said that the difficult struggle to emerge from the small hole actually pushes liquids from deep inside the butterfly's body cavity into the tiny capillaries in the wings, where they harden to complete the healthy and beautiful adult butterfly.

Remember: WITHOUT THE STRUGGLE, THERE ARE NO WINGS!

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Positive Character Qualities – Session 7

accountable	affectionate	appreciative	assertive
brave	careful	caring	clever
compassionate	confident	considerate	cooperative
courageous	courteous	creative	decisive
dependable	determined	direct	empathic
enjoyable	enthusiastic	energetic	feeling
forgiving	friendly	fun	generous
gentle	goal oriented	good sport	grateful
helpful	honest	humble	idealistic
insightful	intelligent	inventive	joyful
kind	loving	loyal	modest
neat	orderly	outgoing	patient
peaceful	persistent	polite	purposeful
punctual	quiet	reliable	resourceful
respectful	responsible	self-assured	self-controlled
self-disciplined	sensitive	sincere	smart
supportive	tactful	team player	tenacious
thoughtful	tolerant	trustworthy	truthful

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING

In-Class Play Session Skills Checklist:

For Review of Videotaped (or Live) Play Session – Session 7

Directions: Indicate ✓ in blank when you observe a play session skill demonstrated in videotaped or live play session

1. ___ Set the Stage/Structured Play Session

2. ___ Conveyed "Be With" Attitudes
   Full attention/interested
   Toes followed nose

3. ___ Allowed Child to Lead
   Avoided giving suggestions
   Avoided asking questions
   Returned responsibility to child

4. ___ Followed Child's Lead
   Physically on child's level
   Moved closer when child was involved in play
   Joined in play when invited—took imaginary/pretend role when appropriate

5. ___ Reflective Responding Skills:

   ___ Reflected child's nonverbal play behavior (Tracking)

   ___ Reflected child's verbalizations (Content)

   ___ Reflected child's feelings/wants/wishes

   ___ Voice tone matched child's intensity/affect

   ___ Responses were brief and interactive

   ___ Facial expressions matched child's affect

6. ___ Used Encouragement/Self-Esteem-Building Responses

7. ___ Set Limits, As Needed, Using A-C-T

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Parent Play Session Notes – Session 7

Play Session #_____ Date: _____

Significant Happenings:

What I Learned About My Child:

Feelings Expressed:

Play Themes:

What I Learned About Myself:

My feelings during the play session:

What I think I was best at:

What was hardest or most challenging for me:

Questions or Concerns:

Skill I Want to Focus on in the Next Play Session: _____

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Play Session Skills Checklist - Session 7

Play Session #_____ Date: _____

(Note: Indicate ✓ in column if skill was used; — if skill was not used; and + if skill was a strength)

✓— +	Skill	Notes/Comments
	Set the Stage/Structured Play Session	
	Conveyed "Be With" Attitudes *Full attention/interested* *Toes followed nose*	
	Allowed Child to Lead *Avoided giving suggestions* *Avoided asking questions* *Returned responsibility to child*	
	Followed Child's Lead *Physically on child's level* *Moved closer when child was involved in play* *Joined in play when invited*	
	Reflective Responding Skills:	
	Reflected child's nonverbal play (Tracking)	
	Reflected child's verbalizations (Content)	
	Reflected child's feelings/wants/wishes	
	Voice tone matched child's intensity/affect	
	Responses were brief and interactive	
	Facial expressions matched child's affect	
	Use of Encouragement/Self-Esteem-Building Responses	
	Set Limits, As Needed, Using A-C-T	

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Parent Notes & Homework – Session 8

RULE OF THUMB TO REMEMBER:

"Encourage the effort rather than praise the product!"

Children need encouragement like a plant needs water.

Notes (use back for additional notes):

Homework Assignments:

1. Read *Encouragement vs. Praise*—practice giving at least one encouragement response during your play session (note on *Play Session Skills Checklist*). Also practice giving at least one encouragement outside of your play session.

   What happend or what child said (outside of play session) _____
   What you said _____
   How child responded (verbally or nonverbally)_____

2. Write down one issue you are struggling with most outside of play session time.

   _____

3. Conduct play session (same time & place)—review *Play Session Do's & Don'ts & Play Session Procedure Checklist*

   a. Complete *Parent Play Session Notes*.

   b. Use *Play Session Skills Checklist* to note what you thought you did well, specifically focus on encouragement responses, and select one skill you want to work on in your next play session.

   ____ I will bring my videotape for next week (if videotaping at clinic: my appt. day/time____).

4. Additional assignment:

Reminder: Write second note to your child of focus, as well as other children in the family, pointing out another positive character quality you appreciate about the child. (Vary how the note is delivered, for example, placing in child's lunchbox, taped to mirror in bathroom, on the child's pillow, under the child's dinner plate, etc.)

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Additional Parents Notes – Session 8

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Encouragement vs. Praise – Session 8

Rule of Thumb: "Encourage the effort rather than praise the product"

Praise: Although praise and encouragement both focus on positive behaviors and appear to be the same process, praise actually fosters dependence in children by teaching them to rely on an external source of control and motivation rather than on self-control and self-motivation. Praise is an attempt to motivate children with external rewards. In effect, the parent who praises is saying, "If you do something I consider good, you will have the reward of being recognized and valued by me." Overreliance on praise can produce crippling effects. Children come to believe that their worth depends upon the opinions of others. Praise employs words that place value judgments on children and focuses on external evaluation.

Examples: "You're such a good boy/girl." *The child may wonder, "Am I accepted only when I'm good?"*
"You got an A. That's great!" *Are children to infer that they are worthwhile only when they make As?*
"You did a good job." "I'm so proud of you." *The message sent is that the parent's evaluation is more important than the child's.*

Encouragement: Focuses on internal evaluation and the contributions children make—facilitates development of self-motivation and self-control. Encouraging parents teach their children to accept their own inadequacies, learn from mistakes (mistakes are wonderful opportunities for learning), have confidence in themselves, and feel useful through contribution. When commenting on children's efforts, be careful not to place value judgments on what they have done. Be alert to eliminate value-laden words (good, great, excellent, etc.) from your vocabulary at these times. Instead, substitute words of encouragement that help children believe in themselves. Encouragement focuses on effort and can always be given. Children who feel their efforts are encouraged, valued, and appreciated develop qualities of persistence and determination and tend to be good problem-solvers. *Note: Parent's voice should match child's level of affect; if child is excited about getting an "A" on a test, parent responds likewise with excitement in her voice, "You're really proud of that!" Use after-the-event celebrations (based on child's pride in achievement) instead of rewards (external motivators to get the child to achieve) to recognize achievement. In the above example, the parent could add "Sounds like something to celebrate; let's make a cake!" or "You choose the restaurant, my treat!"*

Encouraging Phrases That Recognize Effort and Improvement:

"You did it!" or "You got it!"

"You really worked hard on that."

"You didn't give up until you figured it out."

"Look at the progress you've made..." (Be specific)

"You've finished half of your worksheet and it's only 4 o'clock."

Encouraging Phrases That Show Confidence:

"I have confidence in you. You'll figure it out."

"That's a rough one, but I bet you'll figure it out."

"Sounds like you have a plan."

"Knowing you, I'm sure you will do fine."

"Sounds like you know a lot about_____."

Encouraging Phrases That Focus on Contributions, Assets, and Appreciation:

"Thanks, that was a big help."

"It was thoughtful of you to_____" or "I appreciate that you_____."

"You have a knack for _____. Can you give me a hand with that?"

In summary, encouragement is:

1. Valuing and accepting children as they are (not putting conditions on acceptance)
2. Pointing out the positive aspects of behavior
3. Showing faith in children, so that they can come to believe in themselves
4. Recognizing effort and improvement (rather than requiring achievement)
5. Showing appreciation for contributions

Adapted from Dinkmeyer, D., & McKay, G.D. The Parent's Handbook (1982). Circle Pines, Minn: American Guidance Service.

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
In-Class Play Session Skills Checklist:
For Review of Videotaped (or Live) Play Session – Session 8

Directions: Indicate ✓ in blank when you observe a play session skill demonstrated in videotaped or live play session

1. ___ Set the Stage/Structured Play Session

2. ___ Conveyed "Be With" Attitudes
   Full attention/interested
   Toes followed nose

3. ___ Allowed Child to Lead
   Avoided giving suggestions
   Avoided asking questions
   Returned responsibility to child

4. ___ Followed Child's Lead
   Physically on child's level
   Moved closer when child was involved in play
   Joined in play when invited—took imaginary/pretend role when appropriate

5. ___ Reflective Responding Skills:

   ___ Reflected child's nonverbal play behavior (Tracking)

   ___ Reflected child's verbalizations (Content)

   ___ Reflected child's feelings/wants/wishes

   ___ Voice tone matched child's intensity/affect

   ___ Responses were brief and interactive

   ___ Facial expressions matched child's affect

6. ___ Used Encouragement/Self-Esteem-Building Responses

7. ___ Set Limits, As Needed, Using A-C-T

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Parent Play Session Notes – Session 8

Play Session #_____ Date: _____

Significant Happenings:

What I Learned About My Child:

Feelings Expressed:

Play Themes:

What I Learned About Myself:

My feelings during the play session:

What I think I was best at:

What was hardest or most challenging for me:

Questions or Concerns:

Skill I Want to Focus on in the Next Play Session: _____

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Play Session Skills Checklist - Session 8

Play Session #_____ Date: _____

(Note: Indicate ✓ in column if skill was used; — if skill was not used; and + if skill was a strength)

✓— +	Skill	Notes/Comments
	Set the Stage/Structured Play Session	
	Conveyed "Be With" Attitudes *Full attention/interested* *Toes followed nose*	
	Allowed Child to Lead *Avoided giving suggestions* *Avoided asking questions* *Returned responsibility to child*	
	Followed Child's Lead *Physically on child's level* *Moved closer when child was involved in play* *Joined in play when invited*	
	Reflective Responding Skills:	
	Reflected child's nonverbal play (Tracking)	
	Reflected child's verbalizations (Content)	
	Reflected child's feelings/wants/wishes	
	Voice tone matched child's intensity/affect	
	Responses were brief and interactive	
	Facial expressions matched child's affect	
	Use of Encouragement/Self-Esteem-Building Responses	
	Set Limits, As Needed, Using A-C-T	

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Parent Notes & Homework – Session 9

RULES OF THUMB TO REMEMBER:

1. **"Where there are no limits, there is no security."** Consistent Limits = Security in the Relationship. When you don't follow through, you lose credibility and harm your relationship with your child.
2. **"Don't try to change everything at once!"** Focus on 'big' issues that ultimately will mean the most to your child's development of positive self-esteem and feelings of competence and usefulness.

Notes (use back for additional notes):

_____
_____
_____
_____
_____
_____

Homework Assignments:

1. Review *Generalizing Limit Setting to Outside the Play Session*—if applicable, report on a time you used A-C-T outside of the play session.
   What happened _____
   What you said _____
   How child responded (verballly or nonbally)_____
2. Notice the number of times you touch your child in interactions outside the play session (hugging, patting on the head, a touch on the arm, etc.) and keep count this week. # of physical contacts: ____
3. A related assignment is to play-wrestle with your children. (Example: In a two-parent family with small children, Mom and kids can sneak up on Dad and try to get him down on the floor, accompanied by lots of fun and laughter.)
4. Choose one issue you are struggling with outside of the play session to focus on and report back next week on how you can use your play session skills to respond to the issue. _____
   _____
5. Conduct play session (same time & place)—review *Play Session Do's & Don'ts & Play Session Procedure Cheklist*
   a. Complete *Parent Play Session Notes.*
   b. Use *Play Session Skills Checklist* to note what you thought you did well, and select one skill you want to work on in your next play session.

____ ***I will bring my videotape for next week (if videotaping at clinic: my appt. day/time ____).***

6. Additional assignment:

Reminder: Write third note to your child of focus, as well as other children in the family, pointing out another positive character quality you appreciate about the child. (Vary how the note is delivered.)

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Additional Parents Notes – Session 9

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING

Advanced Limit Setting: Giving Choices as Consequences for Non-Compliance - Session 9

Play Session Example: After parent has stated that the playdough is for playing with on the tray, 5-year-old Billy dumps it on the floor. Next, parent follows the A-C-T method of limit setting: "**Billy, I know that you want to play with the playdough over there, but the floor (carpet, etc.) is not for putting playdough on; (pointing to tray) the tray is for putting the playdough on.**" Billy continues to ignore parent and begins to smash the play-dough on the floor. Parent may patiently restate limit up to three times before beginning the next step of stating "If-Then" choices (consequences) for following or not following limit. Note: This example assumes that parent has chosen a location for the play session where the floor surface can be easily cleaned by parent after the session. (of child *begins* to put playdoh on carpet, parent can reach out and guide the playdoh can to the tray as the A-C-T limit is set)

Next step: Begin "If-Then" choice-giving method to provide consequence for unacceptable behavior. *Note the number of times the words "choose" or "choice" are used! Remember that the intent is for the child to bring himself under control; therefore, patience is the order of the day. Children need time and practice to learn self-control.*

Example: "**Billy, If you choose to play with the playdough on the tray (pointing to tray), then you choose to play with the playdough today. If you choose to continue to play with the playdough on the floor, then you choose not to play with the playdough for the rest of today.**" (Pause.) Patiently restate if child does not make the choice to comply with the limit. (If no answer and Billy continues to play with playdough on floor, then he has made his choice.) "**Billy, looks like you've chosen to put the playdough up for today. You can choose to give me the playdough, or you can choose for me to put the playdough up for you; which do you choose?**" If child begins to cry and beg for the playdough, parent must be tough and follow through, acknowledging child's feelings and giving child hope that he will have a chance to make a different choice in the next play session. "**Billy, I understand that you're unhappy that you chose to have the playdough put up for today, but you can choose to play with it in our next play session.**"

In the above example, if at any point the child took the playdough and put it on the tray to play with, the parent must be careful to respond matter-of-factly, "**Looks like you decided you wanted to play with it some more today.**"

Practice:

1. Your child aims a loaded dart gun at you.

A _____.

C _____.

T _____.

Your child continues to aim the gun at you after you have set the limit using A-C-T three times.

If you choose to *aim the gun at me*
then you choose to *not to get to play with the gun.*

If you choose to *aim the gun somewhere else*
then you choose to *get to play with the gun.*

If your child aims and shoots the gun at you, you say:

I see you've chosen not to get to play with the gun.

If your child puts the gun down, you say:

I see you've chosen to play with the gun some more today

2. Describe a situation in which you think you might need to set a limit during the play session and you anticipate the child might not comply.
Situation: _____

A _____

C _____

T _____

If/Then: _____

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Generalizing Limit Setting to Outside the Play Session – Session 9

Acknowledge the feeling
Communicate the limit
Target alternatives

Three-Step A-C-T Method of Limit Setting Followed by Choices (Consequences) for Non-compliance:

Scenario: *Child found your hidden stash of candy, has a piece in his hand, and is starting to unwrap it. (It is 30 minutes before dinner.)*

1. **A**cknowledge your child's feeling or desire (*your voice must convey empathy and understanding*).
   (Empathically) **"Billy, I know you'd really like to have the candy…"**
   Child learns that his feelings, desires, and wishes are valid and accepted by parent (but not all behavior).
   Just empathically reflecting your child's feeling often defuses the intensity of the feeling or need.
2. **C**ommunicate the limit. (Be specific and clear—and brief.)
   "…but candy is not for eating before dinner."
3. **T**arget acceptable alternatives. (Provide one or more choices, depending on age of child.)
   "You can choose to have a piece of fruit now (pointing to bowl of fruit) **and choose to have the piece of candy after dinner."** (If you do not want your children to ever have candy, don't keep it around.)
   The goal is to provide your child with acceptable alternatives—ones that are acceptable to you, the parent, and ones that you believe will allow your child to get his need met (in this case, to have a piece of candy, but not until after dinner—and if he is hungry, to meet that need with an acceptable before-dinner snack).
   Note: Pointing helps redirect child's attention. If child chooses fruit, stop here.
   Patiently restate the limit up to three times, depending on the age of the child, to allow child to struggle with self-control before proceeding to the next step.
4. **Choice-Giving (consequences) as next step after noncompliance** (examples of possible responses):
   Billy continues to say that he doesn't want fruit; he wants the candy.
   — ***"Billy, having candy now is not one of the choices. You can choose to give me the candy now and choose to eat it after dinner, or you can choose for me to put the candy up and choose not to have the candy after dinner. Which do you choose?" (Pause—Billy says nothing.) "If you choose not to choose, you choose for me to choose for you." (Pause.)***
   a) *(Billy gives you the candy.) "I can tell that was a hard decision—I'll put it up here for you for after dinner."*
   b) *(Billy continues to hold on to candy.) "I see you've chosen for me to choose for you" (as you reach for the candy to put it up). After dinner, if Billy comes to you and says "Now can I have the candy?" your response is, "Remember when you chose not to give me the candy before dinner—at that very moment, you chose not to have candy after dinner." Child may continue to plead and cry (because it has worked in the past). BE FIRM—don't give in!*

Practice: It is a school night and 5-year-old Billy wants to watch just 30 more minutes of television before he goes to bed, because his favorite Charlie Brown special is coming on next.

A _____.

C _____.

T _____.

Patiently restate the limit up to three times; Billy doesn't comply. (It's important to remain empathic & calm, but firm.)

You can choose to _____

_____

_____

3. Props and place

Remember: This is a creative business. So you need to decide on a comfortable time and place to do structured doll play and prepare your props (dolls) ahead of time. A good time might be in your child's bedroom in the evening before bedtime (to avoid disruptions and create a routine). You don't need to buy any special dolls—use your child's dolls and stuffed animals or puppets. (Save your money to give yourself a treat after telling a good story—it's a lot of work to tell a really good story!) You can also involve your child in picking out the dolls/stuffed animals by saying "I've got a special story to tell you tonight. It's about a little girl name Lucy who goes to Jane's (the babysitter). To tell the story, we need a Lucy doll, a Mommy doll, a Daddy doll, and a Jane doll. Can you help me pick out a doll (stuffed animal) for each character?" (Make sure you have a selection of your child's dolls/stuffed animals lined up to choose from.) *Note: You need to remember who is who, and the doll figures stay the same person thereafter (you can add new dolls as you use this method to tell different stories, like going to the dentist for the first time, etc.).*

4. How do I start?

You can start this new play experience by using nonthreatening, general daily life activities as the content of the story (e.g., going to the grocery store). This will help you practice and gain skills before plunging into more challenging themes. Focus your story on one theme and don't go beyond five minutes. You can think the story out in your head, or you can jot down brief notes to use as the script.

Helpful hints:

1. It may seem awkward to tell stories and act them out. Be patient with yourself—YOUR CHILD WILL THINK IT'S FUN AND WON'T NOTICE IF YOU MESS UP!
2. Include only those elements in the story that you have control over. Don't say how much fun Lucy is going to have (she may not be having much fun, if she's anxious). If you say something is going to happen at the babysitter's (going to the park, etc.), make sure you ask that the babysitter follow through on that activity the next day. The entire point of the story is to help the child feel more secure by being able to predict what will happen.
3. Don't build on your own feelings when you are telling the story. For example, "Mom is working in the office while Lucy is playing in day care. Mom is thinking of Lucy and she misses Lucy." (Take away the underlined phrase; including your own feelings in the story may make the child feel guilty for you missing her). Remember: The goal is to help Lucy go to day care without feeling anxious, so she can relax and have fun.
4. Make the story realistic and positive. You are the author of the story, so you can make it the way you want it to turn out in real life. Instead of focusing the story on how Lucy doesn't want to leave Mom, make the story go like this: "Lucy and Mom ring the doorbell together (ding-dong!). The door opens and Lucy smiles when she sees Jane. Lucy gives Mom a big hug, and she and Jane wave goodbye to Mom together…." (Remember to let Jane know about your story.)
5. Always end the story on a positive note THAT YOU CAN CONTROL. If the story involves the child not seeing you for several hours (especially if that is part of the concern), always include an "I'm so glad to see you!" reunion with kisses and hugs. The graphic representation of using dolls is more powerful than a verbal promise.
6. Your child may get distracted and interrupt the story. Briefly attend to the child, but be sure to finish the story. Telling the story after the child is already in bed helps with distractions. Parent can respond to requests to play with something else by saying, "You can play with your other dolls tomorrow; it's bedtime now." Or, if your child asks for a drink, "As soon as we've finished the story, I'll get you a drink."

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Structured Doll Play for Parents – Session 9

What is structured doll play?

Structured doll play is a lively way of storytelling for parents to help children who are feeling anxious or insecure. It provides a brief and specific experience for the children to prepare them for anxiety-provoking experiences, such as parents' divorce, going over to the babysitter, and so forth, or to help them regain a sense of normalcy and routine after a significant change in their life. It has a specific purpose and a clear message (e.g., Mom is going to come back at the end of the day to pick Lucy up).

Can my child benefit from structured doll play?

If your child is showing anxiety or fear, or has been through a traumatic experience, he/she can probably benefit from you using structured doll play with him/her. Structured doll play works best with children from ages 2–6. However, older or younger children can also benefit from it.

How do I do structured doll play?

1. Creating the story

Structured doll play is basically creative storytelling about specific real life happenings. It is similar to reading a story from a storybook to your child; the major differences are:

A. You create the story instead of reading out of a storybook.

B. The story involves real life characters, such as Mom, Dad, Lucy (your child), babysitter Jane, Grandma, schoolteacher, dentist, and so forth.

C. The story is about real life happenings, usually about future events that are coming up in the next day or two. It can also be a story of routine daily happenings.

D. You have a specific purpose and a clear message. For example: Lucy is reluctant to go to the new day care. She would not let you leave when you dropped her off at day care. Your purpose is helping Lucy to feel more comfortable about going to day care. Your message may be, "Mom is going to return at the end of the day." (It's important that the message fit what the parent believes is of most concern to the child.)

E. You use dolls to enhance the dramatic effect and help your child remember. You can also use sound effects to enrich the story and make it more powerful and fun. Remember, young children understand concrete things like dolls and scenes better than promises and reasons.

2. The making of a story (Think about a beginning, middle, and an end)

Beginning — Don't start off by saying Lucy is going to the babysitter. Start off by giving some background for the story (e.g., a predictable routine, like waking up in the morning).

Middle — Give content to the story by putting in details (e.g., putting on shoes or buckling seat belt). Remember to exaggerate and use sound effects (you'll probably feel silly at first, but children love it!).

End — Remember to end the story. Don't leave your child hanging. End the story with a big kiss. *"Mom drives to the babysitter's (Jane) house and rings the bell (ding-dong). Jane opens the door and Lucy sees Mom. Lucy jumps into Mom's lap. Mom gives Lucy a big hug and a kiss (make kissing noise). Mom and Lucy drive home together. They talk about the day on the way home."*

Steps to making a story:

A) Start with a title sentence (e.g., "This is a story about Lucy going to the babysitter").
B) Introduce the characters by using real names of people.
C) Tell the story (don't use "you" to refer to the doll representing your child. Use your child's name to stay objective, e.g., "Lucy is saying goodbye to Mom" rather than "You are saying goodbye to Mom").

3. Props and place

Remember: This is a creative business. So you need to decide on a comfortable time and place to do structured doll play and prepare your props (dolls) ahead of time. A good time might be in your child's bedroom in the evening before bedtime (to avoid disruptions and create a routine). You don't need to buy any special dolls—use your child's dolls and stuffed animals or puppets. (Save your money to give yourself a treat after telling a good story—it's a lot of work to tell a really good story!) You can also involve your child in picking out the dolls/stuffed animals by saying "I've got a special story to tell you tonight. It's about a little girl name Lucy who goes to Jane's (the babysitter). To tell the story, we need a Lucy doll, a Mommy doll, a Daddy doll, and a Jane doll. Can you help me pick out a doll (stuffed animal) for each character?" (Make sure you have a selection of your child's dolls/stuffed animals lined up to choose from.) *Note: You need to remember who is who, and the doll figures stay the same person thereafter (you can add new dolls as you use this method to tell different stories, like going to the dentist for the first time, etc.).*

4. How do I start?

You can start this new play experience by using nonthreatening, general daily life activities as the content of the story (e.g., going to the grocery store). This will help you practice and gain skills before plunging into more challenging themes. Focus your story on one theme and don't go beyond five minutes. You can think the story out in your head, or you can jot down brief notes to use as the script.

Helpful hints:

1. It may seem awkward to tell stories and act them out. Be patient with yourself—YOUR CHILD WILL THINK IT'S FUN AND WON'T NOTICE IF YOU MESS UP!
2. Include only those elements in the story that you have control over. Don't say how much fun Lucy is going to have (she may not be having much fun, if she's anxious). If you say something is going to happen at the babysitter's (going to the park, etc.), make sure you ask that the babysitter follow through on that activity the next day. The entire point of the story is to help the child feel more secure by being able to predict what will happen.
3. Don't build on your own feelings when you are telling the story. For example, "Mom is working in the office while Lucy is playing in day care. Mom is thinking of Lucy and she misses Lucy." (Take away the underlined phrase; including your own feelings in the story may make the child feel guilty for you missing her). Remember: The goal is to help Lucy go to day care without feeling anxious, so she can relax and have fun.
4. Make the story realistic and positive. You are the author of the story, so you can make it the way you want it to turn out in real life. Instead of focusing the story on how Lucy doesn't want to leave Mom, make the story go like this: "Lucy and Mom ring the doorbell together (ding-dong!). The door opens and Lucy smiles when she sees Jane. Lucy gives Mom a big hug, and she and Jane wave goodbye to Mom together…." (Remember to let Jane know about your story.)
5. Always end the story on a positive note THAT YOU CAN CONTROL. If the story involves the child not seeing you for several hours (especially if that is part of the concern), always include an "I'm so glad to see you!" reunion with kisses and hugs. The graphic representation of using dolls is more powerful than a verbal promise.
6. Your child may get distracted and interrupt the story. Briefly attend to the child, but be sure to finish the story. Telling the story after the child is already in bed helps with distractions. Parent can respond to requests to play with something else by saying, "You can play with your other dolls tomorrow; it's bedtime now." Or, if your child asks for a drink, "As soon as we've finished the story, I'll get you a drink."

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
In-Class Play Session Skills Checklist:
For Review of Videotaped (or Live) Play Session – Session 9

Directions: Indicate ✓ in blank when you observe a play session skill demonstrated in videotaped or live play session

1. ___ Set the Stage/Structured Play Session

2. ___ Conveyed "Be With" Attitudes
   Full attention/interested
   Toes followed nose

3. ___ Allowed Child to Lead
   Avoided giving suggestions
   Avoided asking questions
   Returned responsibility to child

4. ___ Followed Child's Lead
   Physically on child's level
   Moved closer when child was involved in play
   Joined in play when invited—took imaginary/pretend role when appropriate

5. ___ Reflective Responding Skills:

   ___ Reflected child's nonverbal play behavior (Tracking)

   ___ Reflected child's verbalizations (Content)

   ___ Reflected child's feelings/wants/wishes

   ___ Voice tone matched child's intensity/affect

   ___ Responses were brief and interactive

   ___ Facial expressions matched child's affect

6. ___ Used Encouragement/Self-Esteem-Building Responses

7. ___ Set Limits, As Needed, Using A-C-T

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Parent Play Session Notes – Session 9

Play Session #_____ Date: _____

Significant Happenings:

What I Learned About My Child:

Feelings Expressed:

Play Themes:

What I Learned About Myself:

My feelings during the play session:

What I think I was best at:

What was hardest or most challenging for me:

Questions or Concerns:

Skill I Want to Focus on in the Next Play Session: _____

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Play Session Skills Checklist - Session 9

Play Session #_____ Date: _____

(Note: Indicate ✓ in column if skill was used; — if skill was not used; and + if skill was a strength)

✓— +	Skill	Notes/Comments
	Set the Stage/Structured Play Session	
	Conveyed "Be With" Attitudes *Full attention/interested* *Toes followed nose*	
	Allowed Child to Lead *Avoided giving suggestions* *Avoided asking questions* *Returned responsibility to child*	
	Followed Child's Lead *Physically on child's level* *Moved closer when child was involved in play* *Joined in play when invited*	
	Reflective Responding Skills:	
	Reflected child's nonverbal play (Tracking)	
	Reflected child's verbalizations (Content)	
	Reflected child's feelings/wants/wishes	
	Voice tone matched child's intensity/affect	
	Responses were brief and interactive	
	Facial expressions matched child's affect	
	Use of Encouragement/Self-Esteem-Building Responses	
	Set Limits, As Needed, Using A-C-T	

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Parent Notes & Homework – Session 10

RULES OF THUMB TO REMEMBER:

"Good things come in small packages."
Don't wait for big events to enter into your child's world—
the little ways are always with us. Hold onto precious moments!

Notes (use back for additional notes):

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Homework Assignments:

Continue play sessions: If you stop now, the message is that you were playing with your child because you had to, not because you wanted to:

I agree to continue my play sessions with my child of focus for ___ weeks and/or begin sessions with _____ and do for ___ weeks.

Date and time for follow-up meetings: _____

Volunteer meeting coordinator: _____

Recommended Reading:

1. *Relational Parenting* (2000) and *How to Really Love Your Child* (1992), Ross Campbell
2. *Between Parent and Child* (1956), Haim Ginott
3. *Liberated Parents, Liberated Children* (1990), Adele Faber and Elaine Mazlish
4. *How to Talk So Kids Will Listen and Listen So Kids Will Talk* (2002), Adele Faber and Elaine Mazlish
5. *"SAY WHAT YOU SEE" for Parents and Teachers* (2005), Sandra Blackard (Free online resource available at www.languageoflistening.com)

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Additional Parents Notes – Session 10

CHILD-PARENT-RELATIONSHIP (C-P-R) TRAINING
Rules of Thumb & Other Things to Remember – Session 10

Rules of Thumb

1. **Focus on the donut, not the hole!**
   Focus on the relationship (your strengths and your child's strengths), NOT the problem.
2. **Be a thermostat, not a thermometer!**
   Learn to RESPOND (reflect) rather than REACT. The child's feelings are not your feelings and needn't escalate with him/her.
3. **What's most important may not be what you do, but what you do after what you did!**
   We are certain to make mistakes, but we can recover. It is how we handle our mistakes that makes the difference.
4. **The parent's toes should follow his/her nose.**
   Body language conveys interest.
5. **You can't give away what you do not possess.**
   (Analogy: oxygen mask on airplane) You can't extend patience and acceptance to your child if you can't first offer it to yourself.
6. **When a child is drowning, don't try to teach her to swim.**
   When a child is feeling upset or out of control, that is not the moment to impart a rule or teach a lesson.
7. **During play sessions, limits are not needed until they are needed!**
8. **If you can't say it in 10 words or less, don't say it.**
   As parents, we tend to overexplain, and our message gets lost in the words.
9. **Grant in fantasy what you can't grant in reality.**
   In a play session, it is okay to act out feelings and wishes that in reality may require limits.
10. **Big choices for big kids, little choices for little kids.**
    Choices given must be commensurate with child's developmental stage.
11. **Never do for a child that which he can do for himself.**
    You will never know what your child is capable of unless you allow him to try!
12. **Encourage the effort rather than praise the product.**
    Children need encouragement like a plant needs water.
13. **Don't try to change everything at once!**
    Focus on 'big' issues that ultimately will mean the most to your child's development of positive self-esteem and feelings of competence and usefulness.
14. **Where there are no limits, there is no security. (Consistent Limits = Secure Relationship)**
    When you don't follow through, you lose credibility and harm your relationship with your child.
15. **Good things come in small packages.**
    Don't wait for big events to enter into your child's world—the little ways are always with us. Hold onto precious moments!

Other Things to Remember:

1. Reflective responses help children to feel understood and can lessen anger.
2. In play, children express what their lives are like now, what their needs are, or how they wish things could be.
3. In the playtimes, the parent is not the source of answers (reflect questions back to child: "Hmm—I wonder").
4. Don't ask questions you already know the answer to.
5. Questions imply non-understanding. Questions put children in their minds. Children live in their hearts.
6. What's important is not what the child knows, but what the child believes.
7. When you focus on the problem, you lose sight of the child.
8. Support the child's feeling, intent, or need, even if you can't support the child's behavior.
9. Noticing the child is a powerful builder of self-esteem.
10. Empower children by giving them credit for making decisions: "You decided to_____."
11. One of the best things we can communicate to our children is that they are competent. Tell children they are capable, and they will think they are capable. If you tell children enough times they can't do something, sure enough, they can't.
12. Encourage creativity and freedom—with freedom comes responsibility.
13. "We're about to institute a new and significant policy immediately effective within the confines of this domicile."
14. When we are flexible in our stance, we can handle anger much more easily. When parents are rigid in their approach, both parent and child can end up hurt (remember the stiff arm!).
15. When unsure of what to say to child or what to do, ask yourself, "What action or words will most preserve the relationship or do least harm?" Sometimes walking away and saying nothing, or telling the child, "I need to take a time-out to cool off, and then we can talk," is best. Always remember: "Nothing at this moment is more important than my relationship with my child."
    (Also applies to spouses, significant others, etc.)
16. Live in the moment—today is enough. Don't push children toward the future.

APPENDIX H

FORM B APPLICATION

IRB # _____

Date Received in OR _____

THE UNIVERSITY OF TENNESSEE

Application for Review of Research Involving Human Subjects

I. IDENTIFICATION OF PROJECT

1. Principal Investigator:

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Faculty Advisor:

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Department:

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Educational Psychology and Counseling Department
Knoxville, TN 37996-3452

2. Project Classification: Dissertation

3. Title of Project: Child Parent Relationship Therapy: Hope for Disrupted Attachments

4. Starting Date: Upon IRB Approval by the University of Tennessee

5. Estimated Completion Date: November 15, 2008

6. External Funding *(if any)*: none

II. PROJECT OBJECTIVES

The intent of this quantitative study is to explore filial therapy, in particular the Parent Child Relationship Therapy (CPRT) model of filial therapy, as a method of intervention to facilitate attachment behaviors in foster children with attachment difficulties. The founder of filial therapy, Bernard Guerney, used the term *filial* because it is defined as "having or assuming the relationship of child or offspring to parent". Guerney believed that parents were the most emotional significant individuals in the child's life, and as such, could become the primary change agent in regard to the therapeutic process (Landreth & Bratton, 2006). The ultimate goal of filial therapy is to strengthen the relationship between the parent and the child by increasing feelings of warmth, affection, empathy, and trust and to diminish the child's presenting behavioral problems. The goal of this investigation is to determine if CPRT will affect the observed behaviors exhibited by foster children with attachment problems and if CPRT is an affective treatment for foster children with attachment difficulties.

III. DESCRIPTION AND SOURCE OF RESEARCH PARTICIPANTS

The participants in this study will be foster parents and foster children from the East Tennessee area who have permission from the State of Tennessee for the foster child to participate in this investigation (Appendix A). The primary participant will be the foster parents although the foster children will be an indirect participant. The investigator will recruit participants through contacts made with the Department of Health and Human Services (HHS). HHS caseworkers in Morgan and Knox counties will provide brochures to potential participants (Appendix B). In the event that participants are not forthcoming, a news article will be sent to local media in the above mentioned counties advertising the program (Appendix C).

Foster parents who are interested in helping their foster child address attachment problems and who meet criteria will be potential candidates for filial therapy. There are some clinical factors that would preclude the use of a filial therapy, for example, foster parents who are experiencing significant emotional distress or foster children whose emotional difficulties or behaviors are too extensive for the intervention at this time (Landreth & Bratton, 2006). Such participants interested in filial therapy would first be referred to individual therapy to address these issues. Foster parents and foster children who meet the following criteria would be viewed as viable candidates for filial therapy:

- The foster parent must be able to read and write on the 6th grade level
- The foster parent is willing to commit to the 5-Session Filial Therapy format
- The foster parent is willing to commit to two, thirty minute play sessions with their child two times per week during the filial therapy intervention
- The foster child is between the ages of two and nine years of age
- The foster child is able to engage in representational play
- The Intake process indicates that the foster parent and the foster child are appropriate candidates for filial therapy

IV. METHODS AND PROCEDURES

An initial assessment will be conducted to ensure that the foster parent and the foster child are candidates for filial therapy (Appendix D). Screening of the foster parent and foster child's background will be conducted with the investigator assessing if the foster parent and foster child meet criteria for CPRT using the above mentioned criteria. When the foster parent and foster child are considered candidates for filial therapy and when the foster parent agrees to participate with the permission of the State of Tennessee, the investigator will then explain the basics of the intervention and will answer any questions the foster parent may have regarding the process. The participants will further be informed that they may discontinue participation at any time without penalty.

A baseline assessment will be conducted as a pre-test measure using the Randolph Attachment Disorder Questionnaire (Appendix E). The Randolph Attachment Disorder Questionnaire (Randolph, 2000) is a self-report type measure that includes 30 items designed to assess attachment difficulties in children ages two to seventeen years of age. The RADQ will be completed by a foster parent who serves as the foster child's primary caretaker. This assessment instrument is a simple, straight forward questionnaire which can be easily completed by foster parents. This measure will not be used to diagnose an attachment problem; rather, it will be used to assess the extent to which Child-Parent-Relationship Therapy precipitates changes in problematic attachment behaviors. This instrument should never be used solely for the sake of attachment diagnosis.

The Attachment Symptoms Checklist (ASCL) that was used for over 20 years in a residential program known as the Attachment Center in Evergreen, Colorado was the predecessor to the RADQ. This check list included commonly observed behaviors that children with attachment problems typically exhibit. The scale was developed through a pilot study (n=80) that utilized a 40 item attachment system checklist with children that had been diagnosed with no clinical diagnosis or with Attachment Disorder, or Conduct Disorder. The ASCL was revised into a 30 item inventory which became the Attachment Disorder Questionnaire Revised (ADQ-R). This inventory was then studied with children who had a history of maltreatment, diagnosis of Attachment Disorder and with children who had no history of maltreatment, Attachment Disorder or who were never involvement in therapeutic services (N=105). The final revision of the ADQ-R resulted in the development of the RADQ.

The RADQ examines five factors including: 1) delinquent behaviors, 2) social behaviors, 3) antisocial behaviors, 4) unstable behaviors, and 5) controlling behaviors. Participants who complete the questionnaire use a 5-point rating scale to respond to the items on the questionnaire and represent the participant's perception of the child's behavior and or traits. A score of one represents rarely, less than 10% of the time; a score of two represents occasionally, about 25% of the time; a score of three represents sometimes, occasionally present; a score of four represents often, 75% of the time; and a score of five represents usually, 90% of the time. The instrument is scored by adding a cumulative score minus 30 points in order to determine the level of attachment difficulty. A score of 65–75 would indicate a mild form of attachment difficulty associated with an avoidant or anxious sub-type of attachment difficulty; a score of 76–89 would indicate a moderate degree of attachment difficulty; and a score of 90 and above would indicate severe attachment difficulties and associated with an ambivalent sub-type of attachment difficulty.

The RADQ is a published instrument with reliability and criterion-referenced, construct, content, and predictive validity reported (Fairchild, 2006, Randolph, 2000). Test–retest correlation coefficients of .82 for the Attachment Disorder group, and .85 for the non-clinical group were reported regarding reliability. Cronbach's alpha for internal consistency measures for the Attachment Disorder group were .84; .81 was indicated for the maltreated group, which indicate internal consistency for the RADQ (Randolph, 2000). Construct validity was determined by correlating scores on the RADQ with sub-scales in three other published instruments. The Personality Inventory for Children (PIC), indicated two subscales out of six were statistically significant including delinquency ($r = .48$, $p<.001$). The Child Behavior Checklist (CBCL) yielded two out of eight statistically significant subscales including delinquent behavior, $r = .36$, $p<.01$, and the Millon Adolescent Personality Inventory (MAPI) indicated that one subscale out of 12 was statistically significant, personal esteem, $r = .37$, $p<.01$. The correlation between the RADQ and these three standardized instruments was determined through a pre- and post-treatment of clients at the Evergreen Attachment Center (Fairchild, 2006). A replication study by Myeroff, Mertlich & Gross (1999) corroborated the effectiveness of this assessment measure's effectiveness.

Intervention

A Licensed Professional Counselor trained and experienced in Play Therapy and Filial Therapy techniques and supervised by University Faculty will conduct this research using the Landreth Child Parent Relationship Training Model (10-Session Filial Therapy Model). The investigator received training in the Landreth 10-Session Filial Therapy Model from Landreth and Bratton in the summer of 2006 and has practiced this technique since receiving formal training.

This model has been adapted from a 10-Session, one hour per week training program to a 5- Session, three hour per week training with documented success (Harris & Landreth, 1997). Consequently, this research will be modified to a 5-Session, three hours per week

format to facilitate scheduling of both the participants and the investigator and to add to the research literature.

The investigator will present the Filial Therapy skills training program to the foster parents in a group format using a psycho-educational model. Each group will have a minimum of four participants and a maximum of eight participants to ensure maximum benefits from the group design (Landreth & Bratton, 2006). The goal is to recruit fifty participants to take part in this study. The therapists notebook (Appendix F), consist of the following critical teaching and training elements:

- Structuring for success
- Modeling acceptance, reflective listening and focused attention
- Fallibility of the therapist
- Encouraging parent strengths
- Utilizing specific instruction
- Providing concrete examples
- Imparting expert knowledge
- Encouraging role play and practice skills
- Using analogies to increase parent awareness
- Touching the inner world of the parent
- Making suggestions for improvement
- Identifying what is learned from special playtimes
- Identifying shifts or changes in behavior
- Facilitating insight
- Clarifying

The foster parents will be provided a Handbook for Parents that will serve as a detailed guideline for the process (Appendix G). The foster parents will be instructed in the basic skills of filial therapy and a variety of common problems that might develop during the process will be discussed with interventions role modeled by the therapist. Reflective listening skills, empathic responses, effective limit setting, handling interruptions, and commitment to the process are especially emphasized in this procedure. The foster parents will be taught the meaning of different play themes and how to respond to such themes in a caring and therapeutic manner. In addition, the investigator will assist the foster parents in choosing therapeutic toys for home sessions, setting up the play space, and structuring the play time within the home environment.

After the second session, the foster parents will begin to conduct therapeutic play sessions with their foster child in the home two times per week for thirty minutes per session. Subsequent to the five-week intervention, the foster parents will be encouraged to continue once a week CPRT in order to maintain the therapeutic relationship with their foster child.

Following the completion of the 5-Session CPRT intervention, the foster parents will complete a post-test of the Randolph Attachment Disorder Questionnaire. The pre-test and post-test scores of the experimental group will be compared to the pre-test and

post-test scores of the control group using a Two-way Repeated Measures ANOVA for the following questions: (1) Will the pre-test scores of the experimental group be significantly higher ($p > .05$) than the post-test scores of the experimental group on the Randolph Attachment Disorder Questionnaire (RADQ), (2) Will the experimental group score significantly lower ($p < .05$) on the RADQ than the control group, and (3) Is CPRT an effective treatment for foster children with attachment difficulties? The pre-test and post-test scores of the experimental group will be compared to the pre-test and post-test scores of the control group using a Three-Way Repeated Measures ANOVA for the following questions: (1) will the age of the foster child be a factor in determining the effects of CPRT in reducing behaviors associated with attachment difficulties?, (2) will the gender of the foster child be a factor in determining the effects of CPRT in reducing behaviors associated with attachment difficulties?, and (3) will the number of foster homes a child has been placed in be a factor in determining the effects of CPRT in reducing behaviors associated with attachment difficulties? The level of significance between the pre-test and post-test scores of the experimental group and the control group will be measured to determine the overall efficacy of the intervention in regard to the different independent variables.

V. SPECIFIC RISKS AND PROTECTION MEASURES

Minimal risk to participants is expected due to the nature of the filial therapy intervention, i.e., a psycho-educational format and the participant's ability to decide the nature of their responses during the course of the study. However, the participant may experience emotional discomfort related to difficulties with parenting their foster children or as a result of the foster child's behavioral problems or from initiating play sessions with their foster child. There is a possibility that the foster child may experience some emotional discomfort when participating in play sessions with their foster parent. Although minimal risk is expected, the investigator will assess for any potential risk to the participants and will provide foster parents with a list of qualified helping professional that they can contact should the need arise.

Involvement in this study is voluntary and individuals may discontinue participation at any time without penalty. Participants will use a pseudonym on any instrumentation or written documents to ensure confidentiality. The investigator will not use the participants name in any written results of the study. Furthermore, instrumentation documents will be stored in a locked file and will then be stored in the office of Dr. Tricia McClam (Claxton room 448) on the University of Tennessee campus. To adhere to the University of Tennessee's Institutional Review Board policy, all documentation pertaining to this study will be safely stored with Dr. McClam during the study. The signed consent form will be stored for three years subsequent to the study. All other documents and instrumentation will be destroyed after six months.

No incentives or compensation will be offered for participation in this research project.

VI. BENEFITS

Participation in this study will add to the body of knowledge regarding the effectiveness of filial therapy to facilitate attachment behaviors in foster children with attachment difficulties. Additional benefits may be derived from an improved relationship between the foster parent and the foster child and a decrease or extinction of presenting behavioral problems exhibited by the foster child. Secondary benefits may also result if the improved relationship is generalized to other settings such as social relationships, school settings, etc. Participants of the experimental group will receive a $25 stipend and certificate for 15 hours of training credit. The control group will receive a certificate for eight hours of training credit.

VII. METHODS FOR OBTAINING "INFORMED CONSENT" FROM PARTICIPANTS

An initial assessment will be conducted to determine if the foster parent and the foster child are potential candidates for CPRT. Once the participants are assessed as appropriated candidates for the study, the investigator will explain in detail the nature of the statement including, risks, benefits, confidentiality, and the qualifications of the investigator and supervisor. Prospective participants will be informed that their participation is voluntary and that they may discontinue participation at any time during the study. The parent will be asked to sign two copies of the informed consent statement (Appendix I), one for the participant and one that will be filed and locked in the office of Dr. McClam in room 448 of Claxton on the UT campus.

VIII. QUALIFICATIONS OF THE INVESTIGATOR(S) TO CONDUCT RESEARCH

Carolyn Carlisle Hacker is a Licensed Professional Counselor, with fourteen years of play therapy experience, 25 years of experience working with children and families, and 12 years of experience working with foster parents and foster children. She is a doctoral candidate in the Counselor Education program and has received training in play therapy, filial therapy, family therapy, counseling, research, statistics, crisis intervention, and psychological testing and assessment. Dr. Tricia McClam is a tenured professor and Associate Head of the Educational Psychology and Counseling Department. She has been a researcher throughout her academic career and has published on a regular basis.

IX. FACILITIES AND EQUIPMENT TO BE USED IN THE RESEARCH

The University of Tennessee's Department of Educational Psychology and Counseling will provide both security and storage for documentation related to the study. The study will be conducted at the Tennessee Career Center in Wartburg, Tennessee, a letter granting permission to use these facilities is attached (Appendix J). An additional location is being sought at this time to facilitate foster parents in Knox

County. This location and a letter granting permission for the use of facilities will be forthcoming at a later date.

X. RESPONSIBILITY OF THE PRINCIPAL/CO-PRINCIPAL INVESTIGATOR(S)

By compliance with the policies established by the Institutional Review Board of The University of Tennessee the principal investigator subscribes to the principles stated in "The Belmont Report" and standards of professional ethics in all research, development, and related activities involving human subjects under the auspices of The University of Tennessee. The principal investigator(s) further agree that:

1. Approval will be obtained from the Institutional Review Board prior to instituting any change in this research project.

2. Development of any unexpected risks will be immediately reported to Research Compliance Services.

3. An annual review and progress report (Form R) will be completed and submitted when requested by the Institutional Review Board.

4. Signed informed consent documents will be kept for the duration of the project and for at least three years thereafter at a location approved by the Institutional Review Board.

XI. SIGNATURES

ALL SIGNATURES MUST BE ORIGINAL. The Principal Investigator should keep the original copy of the Form B and submit a copy with original signatures for review. Type the name of each individual above the appropriate signature line. Add signature lines for all Co-Principal Investigators, collaborating and student investigators, faculty advisor(s), department head of the Principal Investigator, and the Chair of the Departmental Review Committee. The following information should be typed verbatim, with added categories where needed:

Principal Investigator:

_____

Signature: _____Date: _____

Student Advisor (if any): _____

Signature: _____Date: _____

XII. DEPARTMENT REVIEW AND APPROVAL

The application described above has been reviewed by the IRB departmental review committee and has been approved. The DRC further recommends that this application be reviewed as:

[ ] Expedited Review -- Category(s): _____

OR

[ ] Full IRB Review

Chair, DRC: _____

Signature: _____Date: _____

Department Head: _____

Signature: _____Date: _____

Protocol sent to Research Compliance Services for final approval on:

_____ (Date)

Approved:
Research Compliance Services
Office of Research
1534 White Avenue

Signature: _____Date: _____

For additional information on Form B, contact the Office of Research Compliance Officer or by phone at (865) 974-3466.

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University of Tennessee IRB Approval

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May 7, 2008

IRB#: 7609 B

TITLE: Child Parent Relationship Therapy: Hope for Disrupted Attachments

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C448 Claxton Complex
Campus - 3452

Your project listed above was reviewed and has been granted IRB approval under Expedited review.

This approval is for a period ending one year from the date of this letter. Please make timely submission of renewal or prompt notification of project termination (see item #3 below).

Responsibilities of the investigator during the conduct of this project include the following:

1. To obtain prior approval from the Committee before instituting any changes in the project.
2. If signed consent forms are being obtained from subjects, they must be stored for at least three years following completion of the project
3. To submit a Form D to report changes in the project or to report termination at 12-month or less intervals.

The Committee wishes you every success in your research endeavor. This office will send you a renewal notice (Form R) on the anniversary of your approval date.

Sincerely,

Brenda Lawson

Brenda Lawson
Compliances

APPENDIX I

Informed Consent Statement Experimental Group

Study Title: Child-Parent-Relationship Therapy: Hope for Disrupted Attachments

You are invited to participate in a research project. This study will investigate the effectiveness of filial therapy, in particular, the Child-Parent-Relationship Therapy (CPRT) model of filial therapy, as a method of intervention to facilitate attachment behaviors in foster children with attachment difficulties. The founder of filial therapy, Bernard Guerney, used the term *filial* because it is defined as "having or assuming the relationship of child or offspring to parent". Guerney believed that parents were the most emotional significant individuals in the child's life, and as such, could become the primary change agent in regard to the therapeutic process (Landreth & Bratton, 2006). The ultimate goal of filial therapy is to strengthen the relationship between the foster parent and the foster child by increasing feelings of warmth, affection, empathy, and trust and to diminish the child's presenting behavioral problems. The goal of this investigation is to determine if CPRT will affect the observed behaviors exhibited by foster children with attachment problems and if CPRT is an affective treatment for foster children with attachment difficulties.

INFORMATION ABOUT INVOLVEMENT IN THIS STUDY:

You will be asked to participate in a 5- Session, three hours per session training that will be structured in a group format that will consist of three to seven other foster parents. This training will help you to learn the basic skills of CPRT. These skills include reflective listening, empathic responses, effective limit setting, handling interruptions, and commitment to the relationship process. These skills will be discussed and role modeled in detail by the investigator and you will be given the opportunity to discuss and address these skills and presenting issues as needed. A parent handbook will be provided to you that further serves as a guideline for the process as well as a place for you to record notes or ideas. Once you have been demonstrated the CPRT skills (usually after the second week of training) you will also be asked to conduct therapeutic play sessions with your foster child in your home two times per week for thirty minutes each play session. The investigator will assist you in choosing therapeutic toys for home sessions, setting up the play space, and structuring the play time within the home environment.

You will also be taught the meaning of different play themes and how to respond to these themes in a caring and therapeutic manner. In addition, a variety of common problems that might develop during the process will be discussed with interventions role modeled by the investigator.

You will be asked to complete a Randolph Attachment Disorder Questionnaire. This instrument will be completed before the intervention and again after the 5-week intervention is concluded. This instrument will in *no way* be used to make an attachment

diagnosis of any kind, rather, it will be used to assess the extent to which Child-Parent-Relationship Therapy effects changes in problematic attachment behaviors and whether or not CPRT is an effective treatment intervention for foster children with attachment problems.

RISKS OF PARTICIPATION:

Minimal risks are expected due to the psycho-educational format of the study and your ability to decide the nature of your responses to questions or exercises. However, you may experience emotional discomfort related to difficulties with foster parenting or as a result of discussing your foster child's behavioral problems. You may experience emotional discomfort when initiating play sessions with your foster child and there is a possibility that your foster child will also experience emotional discomfort when participating in play. Although minimal risk is expected, the investigator is a Licensed Professional Counselor and will assess for any potential risk. You will be provided a list of qualified helping professional that you can contact should the need arise.

_____ Participant's initials

BENEFITS OF PARTICIPATION:

Your participation in this study will add to the body of knowledge regarding the effectiveness of filial therapy, in particular the Child-Parent-Relationship Therapy model of filial therapy, for facilitating attachment behaviors in foster children with attachment difficulties. Additional benefits may be derived from an improved relationship between you and your foster child and a decrease or extinction of presenting behavioral problems exhibited by your foster child. Secondary benefits may also result if the improved relationship or behaviors are generalized, or carried over to other settings such as other social relationships, school settings, etc.

CONFIDENTIALITY:

All information collected in the course of this research project will be kept confidential. Data will be stored securely and will be made available only to persons conducting the study unless participants specifically give permission in writing to do otherwise. No reference will be made in oral or written reports which could link participants to the study. The signed consent form obtained during the course of this study will be kept for three years in a locked and secure location. All other documentation and instrumentation will be destroyed after six months.

CONTACT INFORMATION:

If you have questions at any time about the study or the procedures, (or you experience adverse effects as a result of participating in this study,) you may contact the researcher, Carolyn Carlisle Hacker, at 529 Claxton Addition, University of Tennessee; phone: 865-974-9297; or email: chacker1@utk.edu. If you have questions about your rights as a participant, contact the Office of Research Compliance Office at (865) 974-3466.

PARTICIPATION

Your participation in this study is voluntary; you may discontinue participation at any time without penalty and without loss of benefits to which you are otherwise entitled. If you withdraw from the study before data collection is completed your data will be returned to you or destroyed.

CONSENT

I have read and understand the above information, received a copy of this form, and agree to participate in this study.

Participant's name (printed) _____ Date _____

Participant's signature_____ Date _____

Investigator's signature _____ Date _____

(Carolyn Carlisle Hacker)

APPENDIX J

Informed Consent Statement Control Group

Study Title: Child-Parent-Relationship Therapy: Hope for Disrupted Attachments

You are invited to participate in a research project. This study will investigate the effectiveness of filial therapy, in particular, the Child-Parent-Relationship Therapy (CPRT) model of filial therapy, as a method of intervention to facilitate attachment behaviors in foster children with attachment difficulties. The founder of filial therapy, Bernard Guerney, used the term *filial* because it is defined as "having or assuming the relationship of child or offspring to parent". Guerney believed that parents were the most emotional significant individuals in the child's life, and as such, could become the primary change agent in regard to the therapeutic process (Landreth & Bratton, 2006). The ultimate goal of filial therapy is to strengthen the relationship between the foster parent and the foster child by increasing feelings of warmth, affection, empathy, and trust and to diminish the child's presenting behavioral problems. The goal of this investigation is to determine if CPRT will affect the observed behaviors exhibited by foster children with attachment problems and if CPRT is an affective treatment for foster children with attachment difficulties.

INFORMATION ABOUT INVOLVEMENT IN THIS STUDY:

You will be asked to participate in a 5- Session, one and a half hour per session control group that will be structured in a support group format that will consist of four to ten other foster parents. This support group will provide an opportunity to discuss and process the challenges of being a foster parent with foster parents just like you, who are experiencing similar challenges and successes. In addition, this support group will provide a forum for accessing resources available to foster parents and foster children and for addressing and promoting quality foster care. An experienced Licensed Professional Counselor will be available to facilitate the group and for consultation and referrals.

You will be asked to complete a Randolph Attachment Disorder Questionnaire that asks questions about your foster child's behavior. This instrument will be completed before the support group begins and again after the 5-week support group is concluded. This instrument will in *no way* be used to make an attachment diagnosis of any kind, rather, it will be used to assess the extent to which Child-Parent- Relationship Therapy effects changes in problematic attachment behaviors and whether or not CPRT is an effective treatment intervention for foster children with attachment problems.

RISKS OF PARTICIPATION:
Minimal risks are expected due to the support format of the study and your ability to decide the nature of your responses to questions or exercises. However, you may

_____ Participant's initials

experience emotional discomfort related to difficulties with foster parenting or as a result of discussing your foster child's behavioral problems. Although minimal risk is expected the investigator is a Licensed Professional Counselor and will assess for any potential risk. You will be provided a list of qualified helping professional that you can contact should the need arise.

BENEFITS OF PARTICIPATION:

Your participation in this study will add to the body of knowledge regarding the effectiveness of filial therapy, in particular the Child-Parent-Relationship Therapy model of filial therapy, for facilitating attachment behaviors in foster children with attachment difficulties. Additional benefits may be derived from an increase in self-confidence regarding your role as a foster parent and from the development of social relationships with other foster parents. In addition, you may experience an improved relationship between you and your foster child as a result of your participation in this support group.

CONFIDENTIALITY:

All information collected in the course of this research project will be kept confidential. Data will be stored securely and will be made available only to persons conducting the study unless participants specifically give permission in writing to do otherwise. No reference will be made in oral or written reports which could link participants to the study. The signed consent form obtained during the course of this study will be kept for three years in a locked and secure location. All other documentation and instrumentation will be destroyed after six months.

CONTACT INFORMATION:

If you have questions at any time about the study or the procedures, (or you experience adverse effects as a result of participating in this study,) you may contact the researcher, Carolyn Carlisle Hacker, at 529 Claxton Addition, University of Tennessee; phone: 865-974-9297; or email: chacker1@utk.edu. If you have questions about your rights as a participant, contact the Office of Research Compliance Office at (865) 974-3466.

PARTICIPATION

Your participation in this study is voluntary; you may discontinue participation at any time without penalty and without loss of benefits to which you are otherwise entitled. If you withdraw from the study before data collection is completed your data will be returned to you or destroyed.

_____ Participant's Initials

CONSENT

I have read and understand the above information, received a copy of this form, and agree to participate in this study.

Participant's name (printed) _____ Date _____

Participant’s signature_____ Date _____

Investigator's signature _____ Date _____

(Carolyn Carlisle Hacker)

VITA

Carolyn Carlisle Hacker is a Licensed Professional Counselor with seventeen years of experience working with children, adolescents, adults, and families including foster families. She is certified by the National Board of Cognitive Behavioral Therapists as a Certified Cognitive Behavioral Therapist and Certified Domestic Violence Counselor, and by the National Board of Forensic Counselors as Certified Forensic Counselor. She further holds the credential of Board Certified Professional Counselor by the American Psychotherapy Association. She is currently an Assistant Professor in the Psychology Department at Carson-Newman College in East Tennessee where she teaches developmental psychology, play therapy, counseling theories and techniques, and forensic psychology.